2021 External Quality Review

HEALTHY BLUE

Submitted: July 2, 2021

Prepared on behalf of the
South Carolina Department
of Health and Human Services

Table of Contents

EXECUTIVE SUMMARY

The Balanced Budget Act of 1997 (BBA) requires State Medicaid Agencies that contract with Managed Care Organizations (MCOs) to evaluate their compliance with state and federal regulations in accordance with *42 Code of Federal Regulations (CFR) 438.358*. This report contains a description of the process and the results of the 2021 External Quality Review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) on behalf of the South Carolina Department of Health and Human Services (SCDHHS). This review determines the level of performance demonstrated by Healthy Blue since the 2020 Annual Review.

The goals of the review are to:

- Determine if Healthy Blue is following service delivery as mandated in the MCO contract with SCDHHS and in the federal regulations
- Evaluate the status of deficiencies identified during the 2020 external quality review and any ongoing quality improvements taken to remedy those deficiencies
- Provide feedback for potential areas of further improvement
- Validate contracted health care services are being delivered and of good quality

The process CCME used for the EQR is based on the protocols the Centers for Medicare & Medicaid Services (CMS) developed for Medicaid MCO EQRs. The review includes a desk review of documents, a two-day virtual onsite visit, a Telephonic Provider Access Study, compliance review, validation of performance improvement projects, validation of performance measures, and validation of satisfaction surveys.

Summary and Overall Findings

Federal regulations require MCOs to undergo a review to determine compliance with federal standards set forth in *42 CFR Part 438 Subpart D* and the Quality Assessment and Performance Improvement (QAPI) program requirements described in *42 CFR § 438.330*. Specifically, the requirements related to:

- Availability of Services *(§ 438.206, § 457.1230)*
- Assurances of Adequate Capacity and Services *(§ 438.207, § 457.1230)*
- Coordination and Continuity of Care *(§ 438.208, § 457.1230)*
- Coverage and Authorization of Services *(§ 438.210, § 457.1230, § 457.1228)*
- Provider Selection *(§ 438.214, § 457.1233)*
- Confidentiality *(§ 438.224)*

- Grievance and Appeal Systems *(§ 438.228, § 457.1260)*
- Subcontractual Relationships and Delegation *(§ 438.230, § 457.1233)*
- Practice Guidelines *(§ 438.236, § 457.1233)*
- Health Information Systems *(§ 438.242, § 457.1233)*
- Quality Assessment and Performance Improvement Program *(§ 438.330, § 457.1240)*

To access Healthy Blue's compliance with the quality, timeliness, and accessibility of services, CCME's review was divided into six areas. The following is a high-level summary of the review results for those areas.

Administration:

42 CFR § 438.224, 42 CFR § 438.242, 42 CFR § 438, and 42 CFR § 457

Healthy Blue has policies and procedures in place describing their general approach to business operations. These policies are reviewed and revised as needed to comply with all applicable federal and state standards and regulations. The organizational structure and lines of communication are clearly defined.

Healthy Blue's Information Systems Capabilities Assessment (ISCA) documentation indicates the MCO can safely collect, store, and process Medicaid claims. Healthy Blue meets the claims payment requirements in the *SCDHHS Contract*. Additionally, the organization is committed to the principle of "minimum access necessary" and the principle is applied in its security policies and procedures. The ISCA documentation indicates security policies and procedures are regularly reviewed and updated. Finally, Healthy Blue takes the recoverability of its information systems seriously by conducting several disaster recovery exercises each year.

The Healthy Blue by BlueChoice Health Plan of South Carolina Program Integrity Plan describes processes to safeguard against fraud, waste, and abuse. Staff training about legal and ethical obligations under applicable laws, regulations, and policies is provided. The Compliance Committee directly reports to Healthy Blue administrative leadership to maintain interdepartmental awareness and compliance.

Compliance training is provided to all new employees within 30 days of their date of hire. Each year thereafter, every employee must take the company's Compliance Challenge refresher course, which covers ethics, the code of conduct, HIPAA privacy and security, and fraud, waste, and abuse (including The False Claims Act and other relevant legislation).

Provider Services:

42 CFR § 10(h), 42 CFR § 438.206 through § 438.208, 42 CFR § 438.214, 42 CFR § 438.236, 42 CFR § 438.414, 42 CFR § 457.1230(a), 42 CFR § 457.1230(b), 42 CFR § 457.1230(c), 42 CFR § 457.1233(a), 42 CFR § 457.1233(c), 42 CFR § 457.1260

Healthy Blue's Credentialing Committee is responsible for credentialing and recredentialing activities for medical providers, is chaired by a Medical Director, and includes network providers with various specialties. Processes and requirements for provider credentialing and recredentialing are documented in the Healthy Blue Credentialing Program Plan and in associated policies, and Healthy Blue follows National Committee for Quality Assurance (NCQA) credentialing standards in addition to required federal and state standards. A review of initial credentialing and recredentialing files revealed missing CLIA certificates for secondary practice locations. Appropriate processes are in place for ongoing monitoring of providers for sanctions and exclusions as well as for restricting, suspending, or terminating providers based on serious quality of care and quality of service issues.

Access standards for primary care providers (PCPs), specialists, and hospitals are defined in policy, and the adequacy of the provider network is monitored through Geo Access reports, Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, analysis of member complaints, and "secret shopper" surveys. As needed, action plans are developed to address problem areas identified with the network. The most recent Geo Access reporting reflected that 100% of members have access to PCPs within the required time/distance standards. For most counties, 100% of members have the required access to specialists. Counties with less than 100% are generally rural counties and efforts continue to recruit additional providers for these counties. The draft 2020 Healthy Blue Practitioner Access Analysis revealed goals were met for after-hours PCP appointment access but not met for urgent care appointments for High Volume specialists. The analysis included key drivers of results, identified barriers, opportunities for improvement, and interventions. Healthy Blue ensures its provider network can serve members with special needs such as hearing or vision impairment, foreign language or cultural requirements, and complex medical needs.

For the Telephone Provider Access Study conducted by CCME, calls were successfully answered 59% of the time. This represents a statistically significant decrease in the successful answer rate from last year's result of 77%. For calls not answered successfully, a little less than half were due to the provider not practicing at the office or phone number listed.

Provider Network Management staff are responsible for provider education activities. The new provider training PowerPoint document and Provider Manual 2021 include information providers need to understand and navigate the health plan. However,

medical record documentation standards to which providers are expected to comply were not located in the Provider Manual. Health plan staff confirmed this information is not provided during provider education sessions and could not specify how providers are informed of the medical record documentation standards.

Preventive health guidelines (PHGs) and clinical practice guidelines (CPGs) are reviewed and approved annually, are posted on Healthy Blue's website, and information about the availability of the PHGs and CPGs is included in the Provider Manual. Provider compliance with guidelines is monitored through Medical Record Compliance Audits, utilization data, and Healthcare Effectiveness Data and Information Set (HEDIS) performance data. For the 2020 Medical Record Compliance Audit, a total of 142 medical records across 30 providers were audited. All records achieved the threshold score of 90%, with most scoring 100%.

Member Services:

42 CFR § 438.206(c), 457.1230(a) 42 CFR § 438. 228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260

Healthy Blue has policies and procedures that define and describe member rights and responsibilities as well as methods of notifying members of their rights and responsibilities. The Evidence of Coverage is Healthy Blue's handbook for members and will be referred to as the Member Handbook throughout this report. New members receive a New Member Packet that includes a copy of the Member Handbook and instructions to begin using benefits and services. Even though Healthy Blue no longer publishes an annual member newsletter, members receive an Annual Member Notice mailer informing them when required annual information is available for viewing on the website. CCME identified minor documentation issues in the Member Handbook and in Policy SC_COXX_126, Annual Notification to Members, and offered recommendations to address them.

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys were conducted by the Center for the Study of Services. The 2020 survey response rates continue to fall below the NCQA target response rate of 40%.

Documentation is maintained by Healthy Blue outlining procedures for grievance filing, acknowledgement, review, and resolution. Policy SC_GAXX 015, Grievance and Appeals for Members, the Member Handbook, 2021 Medicaid Quality Management Program Description, and the plan website were reviewed, and it was found that definitions of terminology and procedures were consistent in description both internally and externally for members. Grievance logs are confidentially managed and are reviewed quarterly to identify and address patterns of need and potential for quality improvements. Files were randomly selected and reviewed with follow-up discussion during the onsite. One Acknowledgement Letter did not meet the five-day standard for timeliness. Most

Grievance Resolution Letters reviewed included information and instructions needed for members to resolve their concern.

Quality Improvement:

42CFR §438.330, 42 CFR §457.1240 (b)

For the Quality Improvement (QI) section, CCME reviewed the QI Program Description, committee structure and minutes, performance measures, performance improvement projects, and the Medicaid Quality Management Program Evaluation for the 2019 Work Plan. The 2021 Quality Management Program Description describes the program's structure, accountabilities, scope, goals, and available resources. The QI Program Description is reviewed and updated at least annually and approved by the Clinical Quality Improvement Committee (CQIC) and the Service Quality Improvement Committee (SQIC).

Healthy Blue's QI Work Plan identifies activities related to program priorities aimed at addressing and improving the quality and safety of clinical care and services. The 2020 and 2021 Work Plans included the planned objectives/activities, dates for completion, responsible parties, and oversight committees. During the previous EQR, CCME recommended Healthy Blue include details and state requirements for each activity and to correct the dates for completion. Healthy Blue incorporated these recommendations into the work plans.

The CQIC charter outlines the committee's responsibilities, meeting frequency, and quorum requirements. Membership of the CQIC includes internal and external health plan staff and network providers.

Provider specific performance data is provided through the Gaps in Care Report sent to network providers annually. This report provides a snapshot of members with care gaps. Other performance data is provided in the HEDIS Measures Trending Report and the ER Diversion Report. Healthy Blue's Provider Manual directs providers to the website for additional information on the QI Program. The reports and information on the website related to Healthy Blue's performance were outdated.

Annually, Healthy Blue evaluates the overall effectiveness of the QI Program and reports this evaluation to the Board of Directors, CQIC, and SQIC for recommendations and approval.

Performance Measure Validation

CCME conducted a validation review of the HEDIS measures following CMS protocols. This process assessed the production of these measures by the health plan to confirm reported

information was valid. The performance measure validation found that Healthy Blue was fully compliant with all HEDIS measures and met the requirements per *42 CFR §438.330 (c) and §457.1240 (b)*. All relevant HEDIS performance measures for the current review year (MY 2019), as well as the previous year (MY 2018) and the change from 2018 to 2019, are reported in the Quality Improvement section of this report.

Healthy Blue produces HEDIS rates using software from two NCQA-certified measure vendors, Inovalon, Inc. and Cotiviti, Inc. The comparison from the previous year to the current year revealed a strong increase in the Initiation of AOD Treatment for Opioid Abuse or Dependence for the total rate and seven and 30-day follow up After Emergency Department Visit for Alcohol and Other Drug Dependence total rates. There were no measures with a substantial decline of greater than 10%. Table 1 highlights the HEDIS measures with substantial increases in rate from last year to the current year.

Table 1: HEDIS Measures with Substantial Changes in Rates

MEASURE/DATA ELEMENT	Measure Year 2018	Measure Year 2019	Change from 2018 to 2019
Substantial Increase in Rate (>10% improvement)			
Initiation and Engagement of AOD Dependence Treatment (iet)			
Opioid abuse or dependence: Initiation of AOD Treatment: Total	41.95%	52.24%	10.29%
After Emergency Department Visit for Alcohol and Other Drug Dependence (fua)			
Total - 30-Day Follow-Up	16.46%	39.32%	22.86%
Total - 7-Day Follow-Up	10.13%	31.07%	20.94%

Quality Withhold Measures

Healthy Blue reported 18 Quality Clinical Withhold Measures for 2019. The 2019 rate, percentile, point value, and index score are shown in *Table 2: Quality Withhold Measures*. The Women's Health rates generated the highest index score, followed by Diabetes, and then Pediatric Preventive Care.

Table 2: Quality Withhold Measures

Measure	MY 2019 Rate	MY 2019 Percentile	Point Value	Index Score
DIABETES				
Hemoglobin A1c (HbA1c) Testing	86.86%	50	4	3.4
HbA1c Control (< =9)	46.47%	50	4	

Measure	MY 2019 Rate	MY 2019 Percentile	Point Value	Index Score
Eye Exam (Retinal) Performed	41.12%	10	2	
Medical Attention for Nephropathy	89.78%	25	3	
WOMEN'S HEALTH				
Timeliness of Prenatal Care	90.08%	90	6	3.9
Breast Cancer Screen	53.28%	25	3	
Cervical Cancer Screen	57.61%	25	3	
Chlamydia Screen in Women (Total)	56.20%	25	3	
PEDIATRIC PREVENTIVE CARE				
6+ Well-Child Visits in First 15 months of Life	76.4%	75	5	3.1
Well Child Visits in 3rd,4th,5th&6th Years of Life	64.58%	10	2	
Adolescent Well-Care Visits	51.58%	25	3	
Weight Assessment/Adolescents: BMI % Total	80.29%	25	3	
BEHAVIORAL HEALTH				
Follow Up Care for Children Prescribed ADHD Medication- Initiation	42.08%	25	3	2.75
Antidepressant Medication Management Effective Continuation Phase Treatment	31.71%	25	3	
Use of First Line Psychosocial Care for children and Adolescents on Antipsychotics- Total	56.2%	25	3	
Metabolic Monitoring for Children and Adolescents on Antipsychotics- Total	27.76%	10	2	
Follow Up After Hospitalization for mental Illness- 7 Day Follow Up Total	31.45%	25	3	
Initiation and Engagement of AOD use or Dependence Treatment: Initiation Total	40.49%	25	3	

Performance Improvement Project Validation

For this review, two Performance Improvement Projects (PIPs) were submitted and validated. Topics for PIPs include Access and Availability to Care and Comprehensive Diabetes Care. *Table 3: Performance Improvement Project Validation Scores* provides an overview of the previous validation scores with the current scores.

Table 3: Performance Improvement Project Validation Scores

Project	Previous Validation Score	Current Validation Score
Access and Availability to Care- Non-Clinical	130/131= 99% High Confidence in Reported Results	100/100= 100% High Confidence in Reported Results
Comprehensive Diabetes Care- Clinical	120/126=95% High Confidence in Reported Results	100/100=100% High Confidence in Reported Results

All the PIPs scored in the "High Confidence in Reported Results" range. There are no corrective actions or recommendations. The Access to Care PIP is now closed and a new PIP will be established to replace it.

The recommendations for last year included initiating or revising interventions for the Access and Availability to Care PIP and to continue to monitor the Adult Access to Preventive Services even with pending closure of the PIP. The PIP document received for this review contained additional measures and data. Staff indicated during the onsite that the additional information added to the PIP document was to monitor Access in innovative ways, as this PIP is being replaced and will be closed for the subsequent review year.

The PIP document showed improvement in the Adults' Access to Preventive/Ambulatory Health Services (AAP) measure although it is still below baseline, and the CAHPS indicator improved slightly from the previous remeasurement to 85.32%, which is above the 81.97% goal. The other indicator added did not have a clear presentation of the indicator definitions, goals, benchmarks, and results. There were several interventions reported including live outreach phone calls, CAHPS education, care reports to providers, ED diversion program, and hold messaging for call center to remind members about preventive services.

The Comprehensive Diabetes Care PIP showed improvement for the Hemoglobin A1c indicator from 85.16% to 85.86% and eye exam indicator from 36.74% to 41.12%, although neither measure has achieved the goal rate. Interventions reported include in home visits, HealthCrowd outreach and event screening, gift card incentives for members, provider coding seminars, and practice consultant onsite visits.

Utilization Management:

42 CFR § 438.210(a–e),42 CFR § 440.230, 42 CFR § 438.114, 42 CFR § 457.1230 (d), 42 CFR § 457. 1228, 42 CFR § 438.228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260, 42 CFR § 208, 42 CFR § 457.1230 (c),42 CFR § 208, 42 CFR § 457.1230 (c)

CCME's assessment of Utilization Management (UM) includes review of the Utilization Management Program Description, program evaluations, policies, member and provider materials, the health plan's website, and approval, denial, appeal, and case management files. Policies and procedures are well-written and clearly define how services are implemented and provided to members.

Healthy Blue's Medical Director and Behavioral Health Medical Director provide oversight and expertise over UM activities. Appropriate reviewers conduct service authorization requests using care guidelines from MCG or other established criteria. Healthy Blue has policies defining processes for handling appeals of adverse benefit determinations. The Care Management policies appropriately document care management processes and services provided. Care Management files indicate care gaps are identified and addressed consistently, and services are provided for various risk levels.

Overall, the review of approval and denial files provided evidence that appropriate UM processes are followed, and no major issues were identified. Review of appeals files indicate that staff do not consistently follow appeal processes outlined in Policy SC_GAXX_051, Member Appeal Process. Issues with handling appeal case file letters and obtaining member consent were identified.

Delegation:

42 CFR § 438.230 and 42 CFR § 457.1233(b)

Processes and requirements for delegation of health plan activities are found in the Delegate/Vendor Oversight and Management Program and in associated policies. Pre-delegation assessment activities are conducted to ensure proposed delegates can meet established contractual and applicable federal, state, and accreditation standards. Once pre-delegation assessment activities are complete and delegation is approved, a delegation agreement between the health plan and the delegate is executed.

For each delegated entity, annual oversight is conducted that includes an assessment of compliance with accreditation standards, contractual requirements, written policies and procedures, and quality activities related to the delegated activities. For utilization and credentialing/recredentialing activities, annual oversight includes a review of files. In addition to annual oversight, delegates provide reports of delegated activities to the health plan on a predetermined schedule. When deficiencies are identified, a corrective action process is initiated, and the delegate is informed in writing of the corrective action required and the timeframe for completion.

Documentation of delegation oversight was submitted for review. Issues were identified related to lack of documentation on the MCO Credentialing File Review Workbook tool related to verification of the National Plan and Provider Enumeration System, a repeat

finding from the previous EQR, and the Social Security Death Master File. Additionally, the tool did not indicate if the collection of nurse practitioner collaborative agreements was verified.

State Mandated Services:

42 CFR § Part 441, Subpart B

Provider compliance with providing Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services and required immunizations is monitored through member medical record documentation reviews and HEDIS reports of well-child visits. During the onsite, it was discussed that state-of-emergency restrictions and guidelines related to the COVID-19 pandemic in 2020 may have negatively contributed to pediatric provider compliance with performing EPSDT/Well Child visits. Healthy Blue is considering conducting a PIP related to developmental screenings to assist members with obtaining required EPSDT and immunization services.

Healthy Blue provides all core benefits specified by the *SCDHHS Contract*. A Quality Improvement Plan item from the 2020 EQR relating to documentation of oversight of credentialing delegates was not addressed.

Quality Improvement Plans and Recommendations from Previous EQR

During the previous EQR, there were six standards scored as "Partially Met" and one standard scored as "Not Met." Following the 2020 EQR, Healthy Blue submitted a Quality Improvement Plan to address the identified deficiencies. CCME reviewed and accepted the Quality Improvement Plan on July 22, 2020. The following is a high-level summary of those deficiencies:

- The process for ensuring that network providers are enrolled with SCDHHS as Qualified Medicaid Providers was not identified.
- Documentation contained errors or omissions in the timeframe for processing credentialing applications.
- Most provider credentialing and recredentialing files reviewed did not contain evidence that the Social Security Death Master File had been queried.
- The Provider Manual referred the reader to the website for definitions of grievance terminology, but the website did not include a glossary or definitions of terminology in the information about grievances.
- The requirement for written consent for a representative to file a grievance on a member's behalf was not addressed in Policy SC_GAXX_015, the Member Handbook, the Provider Manual, and the "Your Grievance and Appeal Rights as a Member of

Healthy Blue" document. Healthy Blue staff reported the health plan does not require written consent for member representation for grievances.

- The "Your Grievance and Appeal Rights as a Member of Healthy Blue" document did not address extensions of grievance resolution timeframes.
- The Grievance Extension Notification letter and the "Your Grievance and Appeal Rights as a Member of Healthy Blue" document did not inform members of the right to file a grievance if they disagree with an extension of the grievance resolution timeframe.
- The review of appeal files revealed issues related to lack of signed Appeal Representative Forms; downgrading expedited appeals to standard appeals without notifying members; lack of evidence of Medical Director review of appeals; not informing members of the timeframe to, or allowing members enough time to, submit additional appeal information; and not following health plan policy for obtaining a signed medical record release before sending appeal case files to members.
- Documentation of oversight of credentialing delegates did not indicate whether the delegates were monitored for querying the National Practitioner Databank (NPDB) and the National Plan and Provider Enumeration System (NPPES).

During the current EQR, CCME assessed the degree to which the health plan implemented the actions to address these deficiencies and found the Quality Improvement Plan for monitoring the NPPES was not implemented. Documentation of oversight of two credentialing delegates did not indicate whether the delegates were monitored for querying the NPPES.

Table 4, Scoring Overview, provides an overview of the scoring of the current annual review as compared to the findings of the 2020 review. For 2021, 207 of 213 standards received a score of "Met." There were four standards scored as "Partially Met" and two standards related to the Telephone Provider Access Study and the implementation of the Quality Improvement Plan from the previous EQR that received a "Not Met" score.

Table 4: Scoring Overview

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards	*Percentage Met Scores
Administration							
2020	40	0	0	0	0	40	100%
2021	40	0	0	0	0	40	100%
Provider Services							
2020	76	3	0	0	0	79	96%
2021	72	2	1	0	0	75	96%
Member Services							
2020	31	2	0	0	0	33	94%
2021	33	0	0	0	0	33	100%
Quality Improvement							
2020	14	0	0	0	0	14	100%
2021	14	0	0	0	0	14	100%
Utilization							
2020	44	0	1	0	0	45	98%
2021	44	1	0	0	0	45	98%
Delegation							
2020	1	1	0	0	0	2	50%
2021	1	1	0	0	0	2	50%
State Mandated Services							
2020	4	0	0	0	0	4	100%
2021	3	0	1	0	0	4	75%
Totals							
2020	**210**	**6**	**1**	**0**	**0**	**217**	**97%**
2021	**207**	**4**	**2**	**0**	**0**	**213**	**97%**

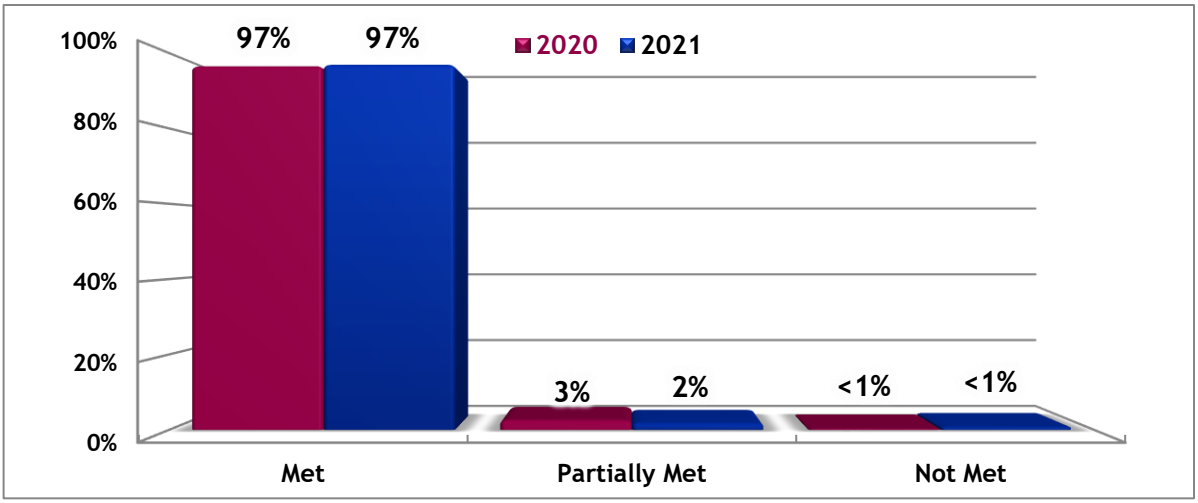
**Percentage is calculated as: (Total Number of Met Standards / Total Number of Evaluated Standards) × 100*

Conclusions

Overall, Healthy Blue met the requirements set forth in *42 CFR Part 438 Subpart D* and the Quality Assessment and Performance Improvement (QAPI) program requirements described in *42 CFR § 438.330*. The 2021 Annual EQR shows that Healthy Blue has achieved a "Met" score for 97% of the standards reviewed. As the following chart indicates, 2% of the standards were scored as "Partially Met," and 0.94% of the standards

scored as "Not Met." The chart that follows provides a comparison of the current review results to the 2020 review results.

Figure 1: Annual EQR Comparative Results



Scores were rounded to the nearest whole number

The following is a summary of key findings and recommendations or opportunities for improvement. Specific details of strengths, weaknesses, and recommendations can be found in the sections that follow.

- The Compliance Overview and Our Values document provides policy references and clear guidelines for Healthy Blue's expectations regarding compliance, confidentiality, conduct, and quality of provided services.
- Healthy Blue takes the recoverability of its information systems seriously by conducting several disaster recovery exercises each year.
- Healthy Blue's Credentialing Committee membership includes an array of external providers.
- The Healthy Blue Credentialing Program Plan references three different frequencies for committee meetings, and the Provider Credentialing/Recredentialing Charter does not define the quorum for Credentialing Committee meetings.
- A review of initial credentialing and recredentialing files revealed issues related to lack of evidence that CLIA certificates were verified for all practice locations.
- Appropriate processes are in place for ongoing monitoring of providers for sanctions and exclusions as well as for restricting, suspending, or terminating providers based on serious quality of care and quality of service issues.
- The adequacy of the provider network and availability of providers is monitored at least annually, and action plans are developed as needed to address problem areas.

- Processes are in place to ensure Healthy Blue's provider network can serve members with special needs such as hearing or vision impairment, foreign language or cultural requirements, and complex medical needs.
- For the Telephone Provider Access Study conducted by CCME, 59% of the calls were answered successfully. This represents a statistical decrease from last year's result of 77%.
- Multiple forums are employed for initial and ongoing provider education. In addition, annual provider training sessions are held in at least four regional locations throughout the state.
- Medical record documentation standards to which providers are expected to comply were not documented in the Provider Manual or in other documents given to providers. Healthy Blue staff confirmed this information is not provided during provider education sessions and could not specify how providers are informed of the specific medical record documentation standards.
- Preventive health guidelines and clinical practice guidelines are reviewed and approved annually. The guidelines are posted on Healthy Blue's website, and information about the availability of the PHGs and CPGs is included in the Provider Manual. Provider compliance with guidelines is monitored through Medical Record Compliance Audits, utilization data, and HEDIS performance gap-in-care data.
- For the 2020 Medical Record Compliance Audit of 142 medical records across 30 providers, all records achieved the threshold score of 90%, with most scoring 100%.
- The website has been updated to clearly list member's rights and responsibilities on a separate landing page.
- New enrollees receive a paper copy of the Member Handbook with the New Member Welcome Kit.
- Health and wellness information is available on the website in the Preventive Health Guidelines and the Healthy Blue Blog sections.
- Most grievance resolution letters reviewed included specific information needed for the member to carry out the resolution steps of their concerns (i.e., phone numbers, provider addresses, and/or contact resources).
- Healthy Blue uses certified software for HEDIS calculations.
- There were no performance measures with a substantial decline of greater than 10%.
- Network providers receive monthly Quality Reports that contain provider specific data regarding assigned members.
- The reports and information on Healthy Blue's website related to the QI Program were outdated.

- All forms for abortions, hysterectomies, and sterilizations are available on the provider website.
- Processes and requirements for delegation of health plan activities are found in the Delegate/Vendor Oversight and Management Program and in associated policies.
- Appropriate pre-delegation assessment activities are conducted to ensure proposed delegates can meet established contractual and applicable federal, state, and accreditation standards.
- Annual oversight is conducted that includes an assessment of delegate compliance with accreditation standards, contractual requirements, written policies and procedures, and quality activities related to the delegated activities. A corrective action process is initiated when deficiencies are identified.
- Documentation of delegation oversight revealed issues related to lack of evidence on the MCO Credentialing File Review Workbook tool related to the delegates verifying the National Plan and Provider Enumeration System, a repeat finding from the previous EQR, and the Social Security Death Master File. Additionally, the tool did not indicate collection of nurse practitioner collaborative agreements was verified.
- Healthy Blue follows the EPSDT periodicity schedule according to the American Academy of Pediatrics.

Recommendations and Opportunities for Improvements

Areas needing corrections and recommendations include:

- Revise credentialing processes to include evidence of CLIA certificates for all applicable practice locations in the credentialing and recredentialing files.
- Examine current methods to update provider information; ensure all provider files are up to date; offer providers several methods to update contact information and primary location. Check the unsuccessful calls file from CCME.
- Revise Policy MCD-04 and Policy MCD-05 to reflect that NCQA credentialing and recredentialing standards are followed.
- Revise the Healthy Blue Credentialing Program Plan to clearly indicate that Credentialing Committee meetings are held monthly.
- Update the Credentialing/Recredentialing Charter to include the quorum for Credentialing Committee meetings.
- Revise the “Provider Directories” policy to include office hours and age groups as required elements of the Provider Directory.
- Update the Provider Manual to include information that members in Waiver services do not have copayments.

- Revise page 3 of Policy SC_QMXX_048 to indicate the correct frequency for review of clinical practice guidelines.
- Revise the Provider Manual to include the specific medical record documentation standards to which providers must comply, as stated in Policy SC_QMXX_105. It is recommended that the standards be posted on the website as well.
- Edit the Evidence of Coverage Change Control Log to include a date indicating when changes were made.
- Correct Policy New Member Packets – Contents to reflect that new member packets are mailed within 14 days of Healthy Blue receiving the member's enrollment data, according to *SCDHHS Contract, Section 3.14.3*.
- Update the Member Handbook to indicate the correct copayment amount for inpatient hospital services and outpatient hospital services (non-emergency) according to the SC Medicaid Copayment Schedule.
- Edit the Member Handbook to include a PCP Selection form or remove the reference of the PCP form.
- Remove the reference to the annual member newsletter in Policy SC_COXX_126, Annual Notification to Members.
- Determine if the survey vendor can offer interventions other than the current methods of oversampling, call script reminders, and website CAHPS banners to improve the CAHPS response rates.
- Update the Quality Improvement Program documents on the Healthy Blue website with current performance data results.
- Follow processes in Policy SC_GAXX_051 Member Appeal Process, to ensure appeal case file letters are mailed to members within 10 days of receiving the appeal request and to ensure member consent is obtained when an appeal is requested from a someone other than the member.
- Provide appeal information on the member's website in a manner that is clearly recognizable and in a location that can be easily accessed, such as under the "grievance and appeals" tab.
- Ensure the updated appeal case file letters are utilized when processing member appeal requests, allowing the member 10 calendar days to respond to the plan.
- Update the Population Health Program Description and the Complex Case Management Program Description to include a description indicating the Care Management Manager is the designated Transition Coordinator who is responsible for oversight of transition of care activities.

- Ensure credentialing delegates are monitored for conducting required queries of the National Plan and Provider Enumeration System and Social Security Death Master File, as well as collection of collaborative agreements between nurse practitioners and supervising physicians. This should be documented in the MCO Credentialing File Review Workbook used to assess credentialing delegates.
- Implement quality improvement plans from the External Quality Review to address all identified deficiencies.

METHODOLOGY

The process CCME used for the EQR activities was based on protocols CMS developed for the external quality review of a Medicaid MCO/PIHP and focuses on the three federally mandated EQR activities of compliance determination, validation of performance measures, and validation of performance improvement projects.

On March 15, 2021, CCME sent notification to Healthy Blue that the Annual EQR was being initiated (see *Attachment 1*). This notification included a list of materials required for a desk review and an invitation for a teleconference to allow Healthy Blue to ask questions regarding the EQR process and the requested desk materials.

The review consisted of two segments. The first was a desk review of materials and documents received from Healthy Blue on March 29, 2021, and reviewed in CCME's offices (see *Attachment 1*). These items focused on administrative functions, committee minutes, member and provider demographics, member and provider educational materials, and the Quality Improvement and Medical Management Programs. Also included in the desk review was a review of credentialing, grievance, utilization, case management, and appeal files.

The second segment was a virtual onsite review conducted on June 2 and 3rd 2021. The onsite visit focused on areas not covered in the Desk Review or needing clarification. See *Attachment 2* for a list of items requested for the onsite visit. onsite activities included an entrance conference; interviews with Healthy Blue administration and staff; and an exit conference. All interested parties were invited to the entrance and exit conferences.

FINDINGS

The EQR findings are summarized below and are based on the regulations set forth in *42 CFR Part 438 Subpart D*, the Quality Assessment and Performance Improvement program requirements described in *42 CFR § 438.330,* and the Contract requirements between Healthy Blue and SCDHHS. Strengths, weaknesses, and recommendations are identified where applicable. Areas of review were identified as meeting a standard "Met," acceptable but needing improvement "Partially Met," failing a standard "Not Met," "Not Applicable," or "Not Evaluated," and are recorded on the tabular spreadsheet (*Attachment 4*).

A. Administration

42 CFR § 438.242, 42 CFR § 457.1233 (d), 42 CFR § 438.224

All policies are located on a shared drive with all-company access. A Compliance Newsletter is emailed to staff that includes a policy section. Links are provided in the

newsletter for applicable policy changes. Amerigroup collaborates with Healthy Blue for similar policies.

Information Systems Capabilities

42 CFR § 438.242, 42 CFR § 457.1233 (d)

Healthy Blue's Information Systems Capabilities Assessment (ISCA) documentation indicates that the MCO can safely collect, store, and process Medicaid claims. Healthy Blue's expectation is that claims must adhere to the following standards: 98% of claims must be processed within 30 days of receipt and 99% of claims must be processed within 90 days of receipt. Additionally, the organization is committed to the principle of "minimum access necessary" and the principle is applied in its security policies and procedures. The ISCA documentation indicates those policies and procedures are regularly reviewed and updated (based upon document revision timestamps). Finally, Healthy Blue takes the recoverability of its information systems seriously by conducting several disaster recovery exercises each year.

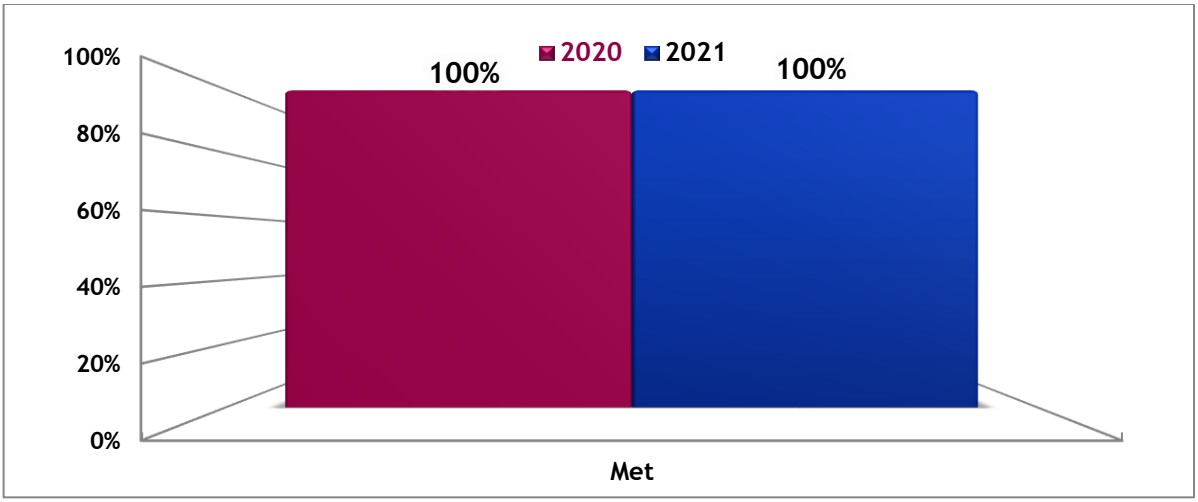
Written policies, procedures, and standards of conduct articulate the organization's commitment to comply with all applicable federal and state standards and regulations. A Program Integrity Plan has been established and includes processes to safeguard against unnecessary or inappropriate use of Medicaid services and against improper payments. Health plan staff are trained on their legal and ethical obligations under applicable laws, regulations, and policies (including federal health care program requirements) is an essential element of Healthy Blue's Compliance Plan.

All new employees are required to complete training on Our Values within 30 days of their date of hire. Each year thereafter, every employee must take the company's Compliance Challenge refresher course, which covers ethics and code of conduct, HIPAA privacy and security, and fraud, waste and abuse (including The False Claims Act and other relevant legislation).

Open lines of communication are encouraged and clearly defined via the company Organizational Chart. Options for reporting suspected compliance, fraud waste and abuse issues are outlined in policies and procedures, as well as in employee manuals and training materials. Information is provided electronically and in other formats including available anonymous methods both internally and externally for reporting options.

Figure 2: Administration Findings shows that 100% of the standards in the Administration section of the review were scored as "Met."

Figure 2: Administration Findings



Strengths

- The Compliance Overview and Our Values document provides policy references and clear guidelines for compliance, confidentiality, conduct, and quality of provided services.
- Healthy Blue takes the recoverability of its information systems seriously by conducting several disaster recovery exercises each year.

B. Provider Services

42 CFR § 10(h), 42 CFR § 438.206 through § 438.208, 42 CFR § 438.214, 42 CFR § 438.236, 42 CFR § 438.414, 42 CFR § 457.1230(a), 42 CFR § 457.1230(b), 42 CFR § 457.1230(c), 42 CFR § 457.1233(a), 42 CFR § 457.1233(c), 42 CFR § 457.1260

The review of Provider Services encompasses credentialing and recredentialing processes and files, adequacy of the provider network and practitioner accessibility, provider education processes, review, dissemination, and evaluation of provider compliance with preventive health and clinical practice guideline, continuity of care, and practitioner medical record requirements.

Provider Credentialing and Selection

Healthy Blue's Credentialing Committee is responsible for credentialing and recredentialing activities for medical providers. The Companion Benefit Alternatives Credentialing Committee conducts these activities for behavioral health providers. The committee is chaired by a Medical Director and membership includes external physicians representing specialties of Dentistry, Pediatrics, Pulmonology, Obstetrics and Gynecology, General Surgery, and Internal Medicine. In addition, there are two Nurse Practitioners and a Chiropractor included in the membership. Onsite discussion and

submitted committee minutes confirmed Credentialing Committee meetings are held monthly. However, the Credentialing Program Description references three different frequencies for committee meetings. The Provider Credentialing/Recredentialing Charter does not define the quorum for Credentialing Committee meetings.

Processes and requirements for provider credentialing and recredentialing are documented in the Credentialing Plan and in associated policies. Onsite discussion confirmed Healthy Blue follows NCQA credentialing standards in addition to required federal and state requirements. A review of initial credentialing and recredentialing files was conducted to assess Healthy Blue's compliance with requirements. Some of files reviewed for independent practitioners did not include CLIA certificates for all practice locations. Onsite discussion confirmed credentialing staff verify the CLIA only for the primary practice location, and CLIA certificates for other locations are maintained elsewhere. A total of five files were reviewed for organizational provider credentialing and recredentialing. No issues were identified.

Appropriate processes are in place for ongoing monitoring of providers for sanctions and exclusions as well as for restricting, suspending, or terminating providers based on serious quality of care and quality of service issues.

Availability of Services

Access standards for primary care providers, specialists, and hospitals are defined in policy. Healthy Blue's QI and Provider Services staff monitor the adequacy of the provider network and availability of providers at least annually through various methodologies, including Geo Access reports, CAHPS surveys, analysis of member complaints, and "secret shopper" surveys. Action plans are developed, as needed, to address problem areas. The Healthy Blue Network Analysis, SC Medicaid Members documents from February 2021 reflect that 100% of members have access to PCPs within the required time/distance standards. For most counties, 100% of members have the required access to specialists. Counties with less than 100% are generally rural counties and efforts continue to recruit additional providers for these counties. The draft 2020 Healthy Blue Practitioner Access Analysis revealed all goals were met for after-hours PCP appointment access. Goals were not met for urgent care appointments for High Volume specialists. The analysis included key drivers of results, identified barriers, opportunities for Improvement, and interventions.

Robust processes are in place to ensure Healthy Blue's provider network can serve members with special needs such as hearing or vision impairment, foreign language or cultural requirements, and complex medical needs. Processes include, but are not limited to, assessing the adequacy of the network based on member population and other variables such as member language preferences; a comprehensive provider awareness

and training program and regular education to provider offices; a "Cultural Competency Issues for Case Managers' training program; offering cultural awareness education for professional staff; and ongoing efforts to recruit minority and Spanish-speaking physicians.

Provider Access and Availability Study

42 CFR § 438.206(c)(1), 42 CFR § 457.1230(a), 42 CFR § 457.1230(b)

The Healthy Blue Provider File contained a population of 2,430 PCPs. From that, a random sample of 176 PCPs was selected for the provider access study. PCPs were chosen based on the following criteria: MD, DO, NP, ANP, CFNP, and FNP. The specialties selected were Family Practice, General Practice, Internal Medicine, Nurse Practitioner, and Pediatrics. Only Providers located in South Carolina and documented as accepting new patients were selected for the sample. Attempts were made to contact these providers to ask a series of questions regarding the access that members have with the contracted providers.

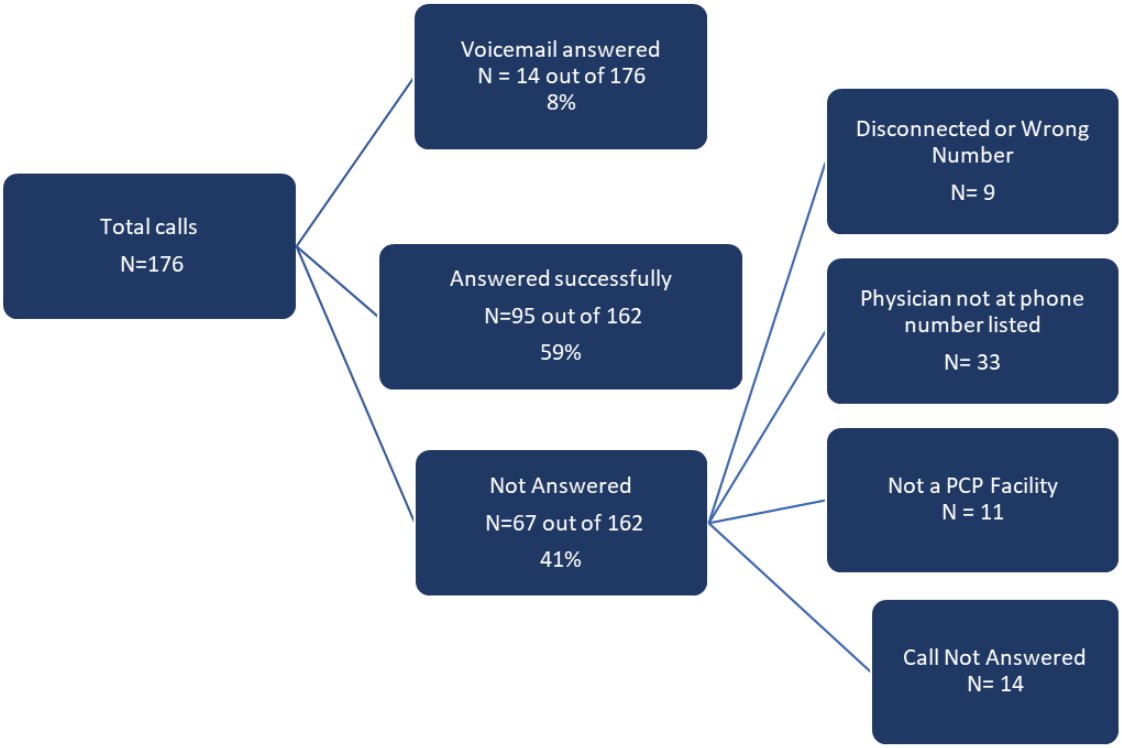
Table 5: Telephonic Access Study Answer Rate Comparison

Review Year	Sample Size	Answer Rate	p-value
2020 Review	209	77%	.0002
2021 Review	176	59%	

In reference to the results of the Telephone Provider Access Study, conducted by CCME, calls were successfully 59% of the time (see Figure 3 below).

Figure 3: Telephonic Provider Access Study Results provides an overview of the findings of the Telephonic Provider Access Study.

Figure 3: Telephonic Provider Access Study Results



When compared to last year's results of 77%, the decrease in successful answer rate was statistically significant (p = .0002). For calls not answered successfully (n=67), 33 (49.3%) were unsuccessful because the provider was not at the office or phone number listed.

There were 95 providers that answered the question, "Do you accept Healthy Blue?" Of those 95, 87 (91.6%) indicated that they accept Healthy Blue, and eight (8.4%) said that they did not accept Healthy Blue.

The next question was, "Are you accepting new Medicaid patients?" A total of 87 providers responded to this question. Of the 87, 65 (74.7%) indicated that they were accepting new patients and 22 (25.3%) said they were not currently accepting new patients.

Regarding a screening process for new patients, 65 providers answered the question. Of those 65, 46 (70.8%) reported that there is a screening process and 19 (29.2%) reported that there is no screening process for new patients.

Of the 46 providers that require screening, five (10.9%) require an application, 12 (26.1%) require medical record review, 26 (56.5%) require both an application and medical record review, and three (6.5%) require other information such as insurance card information,

medical history questionnaire, or information on previous doctors from which care was received.

Provider Education

42 CFR § 438.414, 42 CFR § 457.1260

Provider Network Management staff are responsible for the provider education activities, which are conducted at contracting and periodically as needed. Provider education is provided through forums such as on-site orientation, virtual provider training, providing educational materials and references, provider updates on the website and in special mailings, annual workshops, and routine on-site/virtual contacts. In addition, annual provider training sessions are held in at least four regional locations throughout the state.

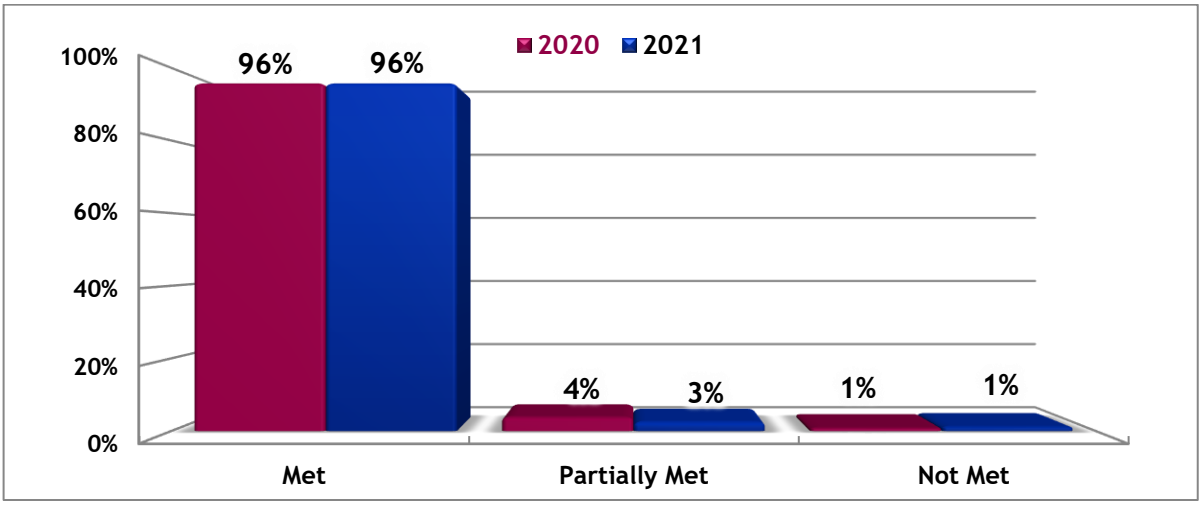
The new provider training PowerPoint document and the Provider Manual include information providers need to understand and navigate the health plan. However, medical record documentation standards to which providers are expected to comply could not be located in the Provider Manual or elsewhere. Healthy Blue staff confirmed this information is not provided during provider education sessions and could not specify how providers are informed of the specific medical record documentation standards. Also, the Provider Manual did not include information that members in Waiver services do not have copayments, which was stated in the Member Handbook.

Preventive health guidelines and clinical practice guidelines are reviewed and approved annually. The guidelines are posted on Healthy Blue's website, and information about the availability of the PHGs and CPGs is included in the Provider Manual. Provider compliance with guidelines is monitored through Medical Record Compliance Audits, utilization data, and HEDIS performance gap-in-care data.

Policy SC_QMXX_105, Medical Record Compliance Audit For Documentation Standards, describes processes and requirements for assessing provider medical record documentation. Healthy Blue provided the results of the 2020 Medical Record Compliance Audit. A total of 142 medical records across 30 providers were audited. All records achieved the threshold score of 90%, with most scoring 100%.

As noted in *Figure 4: Provider Services Findings*, 96% of the Provider Services standards were scored as "Met."

Figure 4: Provider Services Findings



Percentages may not total 100% due to rounding

Table 6: Provider Services Comparative Data

SECTION	STANDARD	2020 REVIEW	2021 REVIEW
Credentialing and Recredentialing	The MCO formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in a manner consistent with contractual requirements	Partially Met	Met
	(Credentialing) Verification of information on the applicant, including: Query of Social Security Administration's Death Master File (SSDMF)	Partially Met	Met
	Clinical Laboratory Improvement Amendment (CLIA) Certificate (or certificate of waiver) for providers billing laboratory procedures	Met	Partially Met
	(Recredentialing) Verification of information on the applicant, including: Query of Social Security Administration's Death Master File (SSDMF)	Partially Met	Met
	Clinical Laboratory Improvement Amendment (CLIA) Certificate for providers billing laboratory procedures	Met	Partially Met

SECTION	STANDARD	2020 REVIEW	2021 REVIEW
Adequacy of the Provider Network	The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results	Met	Not Met

The standards reflected in the table are only the standards that showed a change in score from 2020 to 2021.

Strengths

- The Healthy Blue New Provider Training PowerPoint document is given to providers and is available on the website.
- A variety of forums, including on-site visits, virtual training sessions, printed materials, updates via the website and special mailings, and annual workshops are used to educate and update providers about Healthy Blue and Medicaid.

Weaknesses

- The Credentialing Committee Charter and Policy MCD-06 include statements that Healthy Blue follows NCQA credentialing and recredentialing standards, but similar statements were not noted in Policy MCD-04 and Policy MCD-05.
- Onsite discussion and submitted Credentialing Committee minutes confirmed meetings are held monthly. However, the Credentialing Program Plan:
  - Page 1 states, "The Credentialing Committee is authorized to meet as necessary, but no less than quarterly…"
  - Page 2 states, "Focused Review committee meetings occur bi-monthly beginning in February of each year."
- The Provider Credentialing/Recredentialing Charter does not define the quorum for Credentialing Committee meetings.
- Three of the 14 initial credentialing files and three of the 18 recredentialing files did not include CLIA certificates for all practice locations. Onsite discussion confirmed credentialing staff verify the CLIA only for the primary practice location, and CLIA certificates for other locations are maintained in the Claims area.
- The "Provider Directories" policy lists elements that must be included in the Provider Directory but does not include office hours or age groups, as required by the *SCDHHS Contract, Section 3.13.5.1.1.*
- For the Telephone Provider Access Study, conducted by CCME, calls were successfully 59% of the time. When compared to last year's results of 77%, the decrease in successful answer rate was statistically significant.

- The Member Handbook, page 11, states members in Waiver services do not have copayments. The Provider Manual does not include this information.
- CCME noted that page 2 of Policy SC_QMXX_048 states, "Clinical Practice Guidelines are updated at least annually or when changes are made to national guidelines." However, page 3 states, "The Guidelines Team reviews existing Clinical Practice Guidelines at least every two years or when new evidence is available."
- Policy SC_QMXX_105, Medical Record Compliance Audit For Documentation Standards, states medical record review standards and goals are communicated to practitioners through the Provider Manual. However, the medical record documentation standards were not found in the Provider Manual, and the Provider Manual does not direct the reader to the standards elsewhere, such as on the website. Health plan staff could not identify how providers are educated about the specific medical record documentation standards to which they must comply.

Quality Improvement Plans

- Revise credentialing processes to include evidence of CLIA certificates for all applicable practice locations in the credentialing and recredentialing files.
- Examine current methods to update provider information; ensure all provider files are up to date; offer providers several methods to update contact information and primary location. Check the unsuccessful calls file from CCME.

Recommendations

- Revise Policy MCD-04 and Policy MCD-05 to reflect that NCQA credentialing and recredentialing standards are followed.
- Revise the Credentialing Program Plan, pages 1 and 2, to clearly indicate that Credentialing Committee meetings are held monthly.
- Update the Credentialing/ Recredentialing Charter to include the quorum for Credentialing Committee meetings.
- Revise the "Provider Directories" policy to include office hours and age groups as required elements of the Provider Directory.
- Update the Provider Manual to include information that members in Waiver services do not have copayments.
- Revise page 3 of Policy SC_QMXX_048 to indicate the correct frequency for review of CPGs.

- Revise the Provider Manual to include the specific medical record documentation standards to which providers must comply, as stated in Policy SC_QMXX_105. It is recommended that the standards be posted on the website as well.

C. Member Services

42 CFR § 438.56, 42 CFR § 1212, 42 CFR § 438.100, 42 CFR § 438.10, 42 CFR 457.1220, 42 CFR § 457.1207, 42 CFR § 438.3 (j), 42 CFR § 438. 228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260

The review of Member Services included policies and procedures, member rights, member informational materials, grievances, and the Member Satisfaction Survey. Healthy Blue's Member Handbook is thorough, easily understood, and meets the sixth-grade reading comprehension level as required by SCDHHS. In addition to informing members about their rights and responsibilities, preventive health guidelines, appointment guidelines, and instructions to access benefits, the Member Handbook provides information about obtaining Advance Directives, accessing the Fraud and Abuse Hotline, and how to obtain member materials in alternate languages and alternate formats, such as large font, audio, and Braille.

New members receive a new member packet that includes a copy of the Member Handbook and instructions for accessing the Provider Directory, Notice of Privacy Practices, and how to use benefits and services. A table listing copayments and limits of coverage is included in the Member Handbook. However, CCME identified errors in copayment amounts for inpatient and outpatient hospital services and offered recommendations to correct them.

Even though Policy SC_COXX_126, Annual Notification to Members incorrectly indicates members can obtain annual information from the annual member newsletter, Healthy Blue no longer publishes an annual member newsletter. Instead, members receive an Annual Member Notice mailer informing them when required annual information is available for viewing on the website. Healthy Blue's website has quick links and resources for members to access information such as the Member Handbook, New Member Guide, and Quick start Guide.

Members are informed about the services the Customer Care Center (CCC) provides, its hours of operation, and various methods of contacting health plan representatives. The toll-free CCC telephone number routes calls to Interactive Voice Response (IVR) menus that allow callers to reach appropriate staff during the hours of 8:00 a.m. to 6:00 p.m. Monday through Friday. Healthy Blue monitors the CCC to ensure compliance with performance and response standards. Onsite discussion confirmed performance goals were met for member and provider call centers in 2020.

Healthy Blue contracts with the Center for the Study of Services (CSS), a certified CAHPS survey vendor, to conduct the Child and Adult surveys. The 2020 survey results were presented to the Quality Improvement Committee (QIC) and to network providers. The analysis and implementation of interventions to improve member satisfaction is conducted by the SQIC. Documentation regarding the committee meetings and analysis was submitted in the desk materials.

Even with oversampling, the Child surveys did not meet the minimum sample size of 411 valid surveys, with a total of 192 completed out of 2,145 and the response rate was 8.96%, which is an 8.7% decrease from the 17.7% rate last year. The Adult surveys also used oversampling but had 185 valid surveys out of 1,755, with a response rate of 10.56%, an 8.7% decreased from last year's response rate of 19.3%. The Children with Chronic Conditions (CCC) survey sample was below the target of 411, with 217 completed surveys out of 2,145 for a response rate of 10.12%. This is a decline from the 19% response rate in the previous review. Despite oversampling, the actual sample sizes were not adequate and did not meet the NCQA minimum sample size and number of valid surveys (at least 411), and the response rates were below the NCQA target of 40%.

Grievances

42 CFR § 438. 228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260

Healthy Blue maintains documentation outlining grievance filing requirements and processes for grievance acknowledgement, review, and resolution. Policy SC_GAXX 015, Grievance and Appeals for Members, the Member Handbook, the QI Program Description, and the plan website were reviewed. Grievance terminology and processes were consistently described. It was noted that the 2020 deficiency regarding the revision of the grievance definition wording on the website and in the Provider Manual was addressed. Additionally, grievance processes were revised to include the requirement for written member consent for a grievance to be filed on a member's behalf. Policy SC_GAXX_015, the Member Handbook, the Provider Manual, and the "Your Grievance and Appeal Rights as a Member of Healthy Blue" document were updated to reflect requirements accurately and consistently.

Grievance logs are managed confidentially and are reviewed quarterly to identify and address patterns of need and potential for quality improvement. Grievance files were selected randomly, reviewed, and discussed during the onsite. Verbal explanations were provided satisfactorily by staff in response to onsite questions and file-specific follow-up, including internal monitoring for clinical and quality concerns. One acknowledgement letter was not compliant with the five-day standard for timeliness.

As noted in *Figure 5: Member Services Findings*, Healthy Blue achieved "Met" scores for 100% of the standards for Member Services.

Figure 5: Member Services Findings

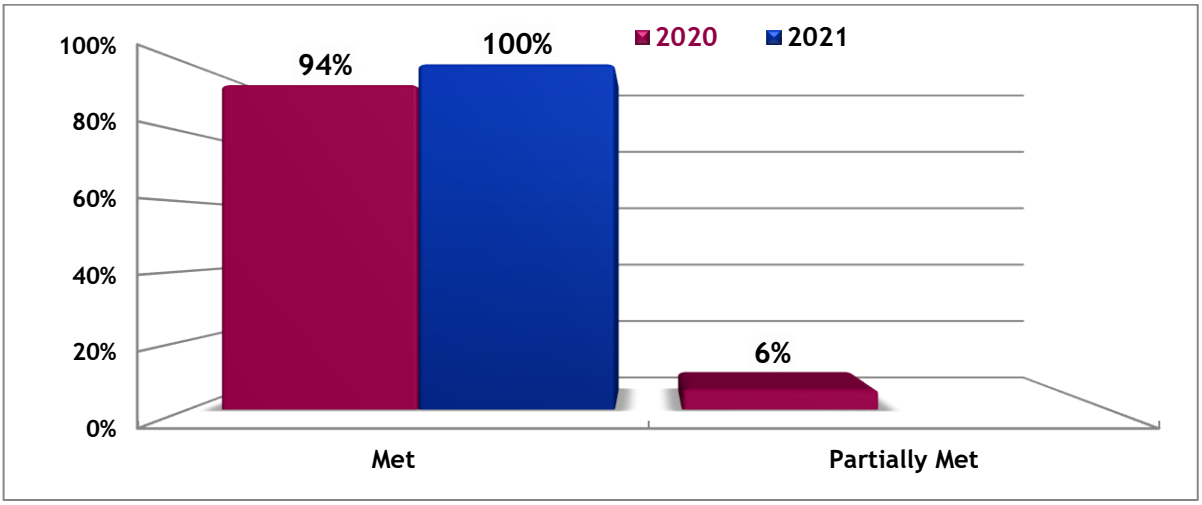


Table 7: Member Services Comparative Data

SECTION	STANDARD	2020 REVIEW	2021 REVIEW
Grievances	The MCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to The definition of a grievance and who may file a grievance	Partially Met	Met
	Timeliness guidelines for resolution of a grievance	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2020 to 2021.

Strengths

- The website has been updated to clearly list member rights and responsibilities.
- New enrollees receive a paper copy of the Member Handbook with the new member welcome kit.
- Health and wellness information is available on the website in the Preventive Health Guidelines and the Healthy Blue Blog sections.

Weaknesses

- The Evidence of Coverage Change Control log does not include a date that indicates when changes occurred.

- The New Member Materials Distribution policy incorrectly states the timeframe for mailing new member packets is no later than the 15th day of the month in which the member is enrolled, instead of no later than 14 calendar days after the plan receives enrollment data.
- The following copayment errors were noted in the Member Handbook:
  - Page 16 states the copayment for Inpatient Hospital Services is $2.00 instead of $25.00.
  - Page 17 notes the copayment for Outpatient Hospital Services for members 19 years of age and older who receive non-emergency services in the emergency room is $3.30 instead of $3.40.
- The Member Handbook does not include a PCP Selection form as indicated on pages one and 21.
- The annual member newsletter has been discontinued; however, Policy, SC_COXX_126, Annual Notification to Members indicates members can refer to it for information on required annual notifications.
- Response rates for the CAHPS surveys were below the NCQA target of 40%.

Recommendations

- Edit the Evidence of Coverage Change Control Log to include dates when changes were made.
- Correct the New Member Materials Distribution policy to reflect that new member packets are mailed within 14 days of Healthy Blue receiving the member's enrollment data, as required by the *SCDHHS Contract, Section 3.14.3*.
- Update the Member Handbook to indicate the correct copayment amount for inpatient hospital services and outpatient hospital services (non-emergency) to be consistent with the SC Medicaid Copayment Schedule.
- Edit the Member Handbook to include a PCP Selection form or remove the reference to the PCP form from the handbook.
- Revise Policy, SC_COXX_126, Annual Notification to Members to remove the reference to the annual member newsletter.
- Determine if CSS can offer interventions other than the current methods of oversampling, call script reminders, and website CAHPS banners to improve CAHPS response rates.

D. Quality Improvement

42 CFR §438.330 and 42 CFR §457.1240(b)

For the Quality Improvement (QI) section, CCME reviewed the QI Program Description, committee structure and minutes, performance measures, performance improvement projects, and the QI program evaluations. The 2021 Quality Management Program Description describes the program's structure, accountabilities, scope, goals, and available resources. The QI Program Description is reviewed and updated at least annually and proved by the Clinical Quality Improvement Committee (CQIC) and the Service Quality Improvement Committee (SQIC).

Healthy Blue's QI Work Plan identifies activities related to program priorities aimed at addressing and improving the quality and safety of clinical care and services. The 2020 and 2021 Work Plans included the planned objective/activity, date for completion, responsible parties, and oversight committees. During the previous EQR, CCME recommended Healthy Blue include details and state requirements for each activity and to correct the dates for completion. Healthy Blue incorporated these recommendations into the work plans.

The CQIC is the local committee responsible for the oversight of the QI Program. The committee charter outlines the committee's responsibilities, meeting frequency and quorum requirements. Membership of the CQIC is composed of internal and external health plan staff and network providers. Current membership includes seven network providers specializing in Family Medicine, Pediatrics, OB/GYN, Emergency Medicine, and Psychiatry. A quorum is met with the attendance of three network providers. Minutes are recorded for each meeting and approved by the originating committee. Healthy Blue provided minutes for the meetings that occurred in 2020 and 2021.

Provider specific performance data is provided through the Gaps in Care Report sent to network providers annually. This report provides a snapshot of members with care gaps. Other performance data is provided in the HEDIS Measures Trending Report and the ER Diversion Report. Healthy Blue's provider manual directs providers to the website for additional information on the QI Program. The reports and information on the website related to Healthy Blue's performance was outdated.

Annually, Healthy Blue evaluates the overall effectiveness of the QI Program and reports this evaluation to the Board of Directors, the CQIC and SQIC for recommendations and approval.

Performance Measure Validation

42 CFR §438.330 (c) and §457.1240 (b)

CCME conducted a validation review of the HEDIS measures following CMS protocols. This process assessed the production of these measures by the health plan to confirm reported information was valid. The performance measure validation found that Healthy Blue was

fully compliant with all HEDIS measures and met the requirements per *42 CFR §438.330 (c) and §457.1240 (b)*.

All relevant HEDIS performance measures for the current review year (MY 2019), as well as the previous year (MY 2018) and the change from 2018 to 2019 are reported in *Table 8: HEDIS Performance Measure Results*. The change in rates shown in green indicates a substantial (>10%) improvement and the rates shown in red indicates a substantial (>10%) decline.

Table 8: HEDIS Performance Measure Results

MEASURE/DATA ELEMENT	Measure Year 2018	Measure Year 2019	PERCENTAGE POINT DIFFERENCE
Effectiveness of Care: Prevention and Screening			
Adult BMI Assessment (aba)	87.35%	87.35%	R
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)			
BMI Percentile	80.29%	80.29%	R
Counseling for Nutrition	67.15%	67.15%	R
Counseling for Physical Activity	62.53%	62.53%	R
Childhood Immunization Status (cis)			
DTaP	75.91%	75.91%	R
IPV	88.08%	88.08%	R
MMR	88.08%	88.08%	R
HiB	83.45%	83.45%	R
Hepatitis B	89.29%	89.29%	R
VZV	87.83%	87.83%	R
Pneumococcal Conjugate	78.10%	78.10%	R
Hepatitis A	83.70%	83.70%	R
Rotavirus	71.29%	71.29%	R
Influenza	41.85%	41.85%	R
Combination #2	71.53%	71.53%	R
Combination #3	69.59%	69.59%	R
Combination #4	67.88%	67.88%	R
Combination #5	60.10%	60.10%	R
Combination #6	36.50%	36.50%	R
Combination #7	59.12%	59.12%	R
Combination #8	36.25%	36.25%	R
Combination #9	32.60%	32.60%	R
Combination #10	32.36%	32.36%	R
Immunizations for Adolescents (ima)			

MEASURE/DATA ELEMENT	Measure Year 2018	Measure Year 2019	PERCENTAGE POINT DIFFERENCE
Meningococcal	72.02%	72.02%	R
Tdap/Td	83.21%	83.21%	R
HPV	29.68%	29.68%	R
Combination #1	71.29%	71.29%	R
Combination #2	28.71%	28.71%	R
Lead Screening in Children (lsc)	70.32%	72.99%	2.67%
Breast Cancer Screening (bcs)	50.95%	53.28%	2.33%
Cervical Cancer Screening (ccs)	57.61%	57.61%	R
Chlamydia Screening in Women (chl)			
16-20 Years	51.96%	53.38%	1.42%
21-24 Years	66.23%	61.82%	-4.41%
Total	56.88%	56.20%	-0.68%
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (cwp)			
3-17 years	NR	86.49%	NA
18-64	NR	74.28%	NA
65+	NR	NA*	NA
Total	NR	83.94%	NA
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	30.25%	25.79%	-4.46%
Pharmacotherapy Management of COPD Exacerbation (pce)			
Systemic Corticosteroid	61.46%	58.53%	-2.93%
Bronchodilator	79.05%	74.68%	-4.37%
Medication Management for People With Asthma (mma)			
5-11 Years - Medication Compliance 50%	56.88%	59.20%	2.32%
5-11 Years - Medication Compliance 75%	31.58%	29.22%	-2.36%
12-18 Years - Medication Compliance 50%	57.09%	52.76%	-4.33%
12-18 Years - Medication Compliance 75%	31.83%	29.14%	-2.69%
19-50 Years - Medication Compliance 50%	59.12%	58.38%	-0.74%
19-50 Years - Medication Compliance 75%	33.15%	30.27%	-2.88%
51-64 Years - Medication Compliance 50%	63.41%	80.85%	17.44%
51-64 Years - Medication Compliance 75%	51.22%	55.32%	4.10%
Total - Medication Compliance 50%	57.61%	58.06%	0.45%
Total - Medication Compliance 75%	32.74%	30.51%	-2.23%
Asthma Medication Ratio (amr)			
5-11 Years	80.04%	80.43%	0.39%
12-18 Years	71.34%	72.65%	1.31%
19-50 Years	54.73%	49.21%	-5.52%
51-64 Years	48.39%	55.22%	6.83%
Total	70.58%	70.40%	-0.18%

MEASURE/DATA ELEMENT	Measure Year 2018	Measure Year 2019	PERCENTAGE POINT DIFFERENCE
Effectiveness of Care: Cardiovascular Conditions			
Controlling High Blood Pressure (cbp)	52.80%	52.80%	R
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	NA*	NA*	NA
Statin Therapy for Patients With Cardiovascular Disease (spc)			
Received Statin Therapy - 21-75 years (Male)	77.29%	78.41%	1.12%
Statin Adherence 80% - 21-75 years (Male)	61.25%	62.36%	1.11%
Received Statin Therapy - 40-75 years (Female)	72.13%	75.00%	2.87%
Statin Adherence 80% - 40-75 years (Female)	57.58%	55.56%	-2.02%
Received Statin Therapy - Total	74.87%	76.85%	1.98%
Statin Adherence 80% - Total	59.59%	59.32%	-0.27%
Effectiveness of Care: Diabetes			
Comprehensive Diabetes Care (cdc)			
Hemoglobin A1c (HbA1c) Testing	85.16%	86.86%	1.70%
HbA1c Poor Control (>9.0%)	49.64%	46.47%	-3.17%
HbA1c Control (<8.0%)	42.58%	44.04%	1.46%
Eye Exam (Retinal) Performed	36.74%	41.12%	4.38%
Medical Attention for Nephropathy	88.81%	89.78%	0.97%
Blood Pressure Control (<140/90 mm Hg)	59.61%	56.69%	-2.92%
Statin Therapy for Patients With Diabetes (spd)			
Received Statin Therapy	61.79%	63.99%	2.20%
Statin Adherence 80%	51.57%	52.38%	0.81%
Effectiveness of Care: Musculoskeletal Conditions			
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (art)	64.29%	NR	NA
Effectiveness of Care: Behavioral Health			
Antidepressant Medication Management (amm)			
Effective Acute Phase Treatment	46.90%	50.38%	3.48%
Effective Continuation Phase Treatment	32.17%	31.71%	-0.46%
Follow-Up Care for Children Prescribed ADHD Medication (add)			
Initiation Phase	38.31%	42.08%	3.77%
Continuation and Maintenance (C&M) Phase	55.75%	56.32%	0.57%
Follow-Up After Hospitalization for Mental Illness (fuh)			
6-17 years - 30-Day Follow-Up	66.67%	66.22%	-0.45%
6-17 years - 7-Day Follow-Up	35.83%	40.09%	4.26%
18-64 years - 30-Day Follow-Up	52.42%	50.35%	-2.07%
18-64 years - 7-Day Follow-Up	30.30%	27.02%	-3.28%
65+ years - 30-Day Follow-Up	NA	NA	NA

MEASURE/DATA ELEMENT	Measure Year 2018	Measure Year 2019	PERCENTAGE POINT DIFFERENCE
65+ years - 7-Day Follow-Up	NA	NA	NA
30-Day Follow-Up	56.22%	55.73%	-0.49%
7-Day Follow-Up	31.78%	31.45%	-0.33%
Follow-Up After Emergency Department Visit for Mental Illness (fum)			
6-17 years - 30-Day Follow-Up	61.08%	68.38%	7.30%
6-17 years - 7-Day Follow-Up	42.09%	48.43%	6.34%
18-64 years - 30-Day Follow-Up	41.44%	47.60%	6.16%
18-64 years - 7-Day Follow-Up	30.02%	31.58%	1.56%
65+ years - 30-Day Follow-Up	NA	NA	NA
65+ years - 7-Day Follow-Up	NA	NA	NA
30-Day Follow-Up	48.66%	56.85%	8.19%
7-Day Follow-Up	34.46%	39.09%	4.63%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (fua)			
13-17 years - 30-Day Follow-Up	NA	NA	NA
13-17 years - 7-Day Follow-Up	NA	NA	NA
18-64 years - 30-Day Follow-Up	NR	39.59%	NA
18-64 years - 7-Day Follow-Up	NR	30.96%	NA
65+ years - 30-Day Follow-Up	NR	NA	NA
65+ years - 7-Day Follow-Up	NR	NA	NA
Total - 30-Day Follow-Up	16.46%	39.32%	22.86%
Total - 7-Day Follow-Up	10.13%	31.07%	20.94%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	75.25%	73.43%	-1.82%
Diabetes Monitoring for People With Diabetes and Schizophrenia (smd)	70.15%	65.36%	-4.79%
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (smc)*	NA*	NA*	NA
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (saa)	64.68%	62.24%	-2.44%
Pharmacotherapy for Opioid Use Disorder (pod)			
16-64 years	NR	29.02%	NA
65+ years	NR	NA	NA
Total	NR	29.02%	NA
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
Blood glucose testing - 1-11 Years	NR	44.83%	NA
Cholesterol Testing - 1-11 Years	NR	25.29%	NA
Blood glucose and Cholesterol Testing - 1-11 Years	NR	25.29%	NA
Blood glucose testing - 12-17 Years	NR	55.70%	NA
Cholesterol Testing - 12-17 Years	NR	32.91%	NA
Blood glucose and Cholesterol Testing - 12-17 Years	NR	29.11%	NA
Blood glucose testing - Total	NR	51.84%	NA

MEASURE/DATA ELEMENT	Measure Year 2018	Measure Year 2019	PERCENTAGE POINT DIFFERENCE
Cholesterol Testing - Total	NR	30.20%	NA
Blood glucose and Cholesterol Testing - Total	NR	27.76%	NA
Effectiveness of Care: Overuse/Appropriateness			
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	0.65%	0.37%	-0.28%
Appropriate Treatment for Children With URI (uri)			
3months-17 Years	NR	87.79%	NA
18-64 Years	NR	67.58%	NA
65+ Years	NR	NA*	NA
Total	NR	85.12%	MA
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)			
3 months-17 Years	NR	57.85%	NA
18-64 Years	NR	31.98%	NA
65+ Years	NR	NA*	NA
Total	NR	49.28%	NA
Use of Imaging Studies for Low Back Pain (lbp)	67.00%	69.62%	2.62%
Use of Opioids at High Dosage (hdo)	5.23%	5.05%	-0.18%
Use of Opioids From Multiple Providers (uop)			
Multiple Prescribers	23.56%	22.84%	-0.72%
Multiple Pharmacies	4.72%	3.89%	-0.83%
Multiple Prescribers and Multiple Pharmacies	1.89%	2.46%	0.57%
Risk of Continued Opioid Use (cou)			
18-64 years - >=15 Days covered	1.99%	2.74%	0.75%
18-64 years - >=31 Days covered	1.51%	2.26%	0.75%
65+ years - >=15 Days covered	NA	NA	NA
65+ years - >=31 Days covered	NA	NA	NA
Total - >=15 Days covered	1.99%	2.74%	0.75%
Total - >=31 Days covered	1.51%	2.26%	0.75%
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (aap)			
20-44 Years	75.57%	76.21%	0.64%
45-64 Years	85.50%	85.13%	-0.37%
*65+ Years**	NA*	NA*	NA
Total	78.51%	78.73%	0.22%
Children and Adolescents' Access to Primary Care Practitioners (cap)			
12-24 Months	97.19%	96.88%	-0.31%
25 Months - 6 Years	86.31%	86.78%	0.47%

MEASURE/DATA ELEMENT	Measure Year 2018	Measure Year 2019	PERCENTAGE POINT DIFFERENCE
7-11 Years	88.40%	88.53%	0.13%
12-19 Years	85.56%	86.15%	0.59%
Initiation and Engagement of AOD Dependence Treatment (iet)			
*Alcohol abuse or dependence: Initiation of AOD Treatment: 13-17 Years**	NA*	NA*	NA
*Alcohol abuse or dependence: Engagement of AOD Treatment: 13-17 Years**	NA*	NA*	NA
*Opioid abuse or dependence: Initiation of AOD Treatment: 13-17 Years**	NA*	NA*	NA
*Opioid abuse or dependence: Engagement of AOD Treatment: 13-17 Years**	NA*	NA*	NA
Other drug abuse or dependence: Initiation of AOD Treatment: 13-17 Years	34.41%	36.84%	2.43%
Other drug abuse or dependence: Engagement of AOD Treatment: 13-17 Years	22.58%	14.29%	-8.29%
Initiation of AOD Treatment: 13-17 Years	32.00%	36.99%	4.99%
Engagement of AOD Treatment: 13-17 Years	21.00%	13.01%	-7.99%
Alcohol abuse or dependence: Initiation of AOD Treatment: 18+ Years	39.57%	38.50%	-1.07%
Alcohol abuse or dependence: Engagement of AOD Treatment: 18+ Years	9.27%	8.72%	-0.55%
Opioid abuse or dependence: Initiation of AOD Treatment: 18+ Years	42.15%	52.14%	9.99%
Opioid abuse or dependence: Engagement of AOD Treatment: 18+ Years	22.46%	24.18%	1.72%
Other drug abuse or dependence: Initiation of AOD Treatment: 18+ Years	40.65%	39.64%	-1.01%
Other drug abuse or dependence: Engagement of AOD Treatment: 18+ Years	10.36%	10.16%	-0.20%
Initiation of AOD Treatment: 18+ Years	38.89%	40.78%	1.89%
Engagement of AOD Treatment: 18+ Years	10.95%	11.87%	0.92%
Alcohol abuse or dependence: Initiation of AOD Treatment: Total	39.27%	38.52%	-0.75%
Alcohol abuse or dependence: Engagement of AOD Treatment: Total	9.60%	8.58%	-1.02%
Opioid abuse or dependence: Initiation of AOD Treatment: Total	41.95%	52.24%	10.29%
Opioid abuse or dependence: Engagement of AOD Treatment: Total	22.49%	24.13%	1.64%
Other drug abuse or dependence: Initiation of AOD Treatment: Total	40.06%	39.31%	-0.75%
Other drug abuse or dependence: Engagement of AOD Treatment: Total	11.52%	10.65%	-0.87%
Initiation of AOD Treatment: Total	38.48%	40.49%	2.01%
Engagement of AOD Treatment: Total	11.55%	11.95%	0.40%
Prenatal and Postpartum Care (ppc)			
Timeliness of Prenatal Care	90.98%	90.98%	R
Postpartum Care	70.22%	70.22%	R

MEASURE/DATA ELEMENT	Measure Year 2018	Measure Year 2019	PERCENTAGE POINT DIFFERENCE
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)			
1-11 Years	NR	50.00%	NA
12-17 Years	61.29%	60.00%	-1.29%
Total	66.07%	56.20%	-9.87%
Utilization			
Well-Child Visits in the First 15 Months of Life (w15)			
0 Visits	0.97%	0.00%	-0.97%
1 Visit	1.46%	0.97%	-0.49%
2 Visits	1.22%	1.95%	0.73%
3 Visits	2.68%	3.41%	0.73%
4 Visits	7.54%	5.60%	-1.94%
5 Visits	10.71%	11.68%	0.97%
6+ Visits	75.43%	76.40%	0.97%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34)	63.75%	64.58%	0.83%
Adolescent Well-Care Visits (awc)	51.58%	51.58%	R

Note. * Indicates small denominator; NR= not reported; NA= not applicable; R= rotated per NCQA allowance

Healthy Blue produces HEDIS rates using software from two NCQA-certified measure vendors Inovalon, Inc. and Cotiviti, Inc. The comparison from the previous to the current year revealed a strong increase in the Initiation of AOD Treatment for Opioid Abuse/Dependence for the total rate and 7- and 30-day follow up After Emergency Department Visit for Alcohol and Other Drug Dependence total rates. There were no measures with a substantial decline of greater than 10%. Table 9 highlights the HEDIS measures with substantial increases in rate from last year to the current year.

Table 9: HEDIS Measures with Substantial Changes in Rates

MEASURE/DATA ELEMENT	Measure Year 2018	Measure Year 2019	Change from 2018 to 2019
Substantial Increase in Rate (>10% improvement)			
Initiation and Engagement of AOD Dependence Treatment (iet)			
Opioid abuse or dependence: Initiation of AOD Treatment: Total	41.95%	52.24%	10.29%
After Emergency Department Visit for Alcohol and Other Drug Dependence (fua)			
Total - 30-Day Follow-Up	16.46%	39.32%	22.86%
Total - 7-Day Follow-Up	10.13%	31.07%	20.94%

Quality Withhold Measures

As required by SCDHHS, there were 12 quality clinical withhold measures reported for MY 2019. The Behavioral Health measures are considered Bonus Only for MY 2019 (reporting year 2020). As per the Medicaid Playbook and Policy and Procedure Guide for Managed Care Organizations, individual measures within the quality index are weighted differently. A point value is assigned for each measure based on percentile (<10 percentile = 1 point; 10-24 percentile = 2 points; 25-49 percentile = 3 points; 50-74 percentile = 4 points; 75-90 percentile = 5 points; >90 percentile = 6 points). Points attained for each measure are multiplied by the weight of an individual measure then summed to obtain the quality index score. *Table 10: Quality Withhold Measures* shows the 2019 rate, percentile, point value, and index score. The Women's Health rates generated the highest index score, followed by Diabetes, and then Pediatric Preventive Care.

Table 10: Quality Withhold Measures

Measure	MY 2019 Rate	MY 2019 Percentile	Point Value	Index Score
DIABETES				
Hemoglobin A1c (HbA1c) Testing	86.86%	50	4	3.4
HbA1c Control (< =9)	46.47%	50	4	
Eye Exam (Retinal) Performed	41.12%	10	2	
Medical Attention for Nephropathy	89.78%	25	3	
WOMEN'S HEALTH				
Timeliness of Prenatal Care	90.08%	90	6	3.9
Breast Cancer Screen	53.28%	25	3	
Cervical Cancer Screen	57.61%	25	3	
Chlamydia Screen in Women (Total)	56.20%	25	3	
PEDIATRIC PREVENTIVE CARE				
6+ Well-Child Visits in First 15 months of Life	76.4%	75	5	3.1
Well Child Visits in 3rd,4th,5th&6th Years of Life	64.58%	10	2	
Adolescent Well-Care Visits	51.58%	25	3	
Weight Assessment/Adolescents: BMI % Total	80.29%	25	3	

Measure	MY 2019 Rate	MY 2019 Percentile	Point Value	Index Score
BEHAVIORAL HEALTH				
Follow Up Care for Children Prescribed ADHD Medication- Initiation	42.08%	25	3	2.75
Antidepressant Medication Management Effective Continuation Phase Treatment	31.71%	25	3	
Use of First Line Psychosocial Care for children and Adolescents on Antipsychotics- Total	56.2%	25	3	
Metabolic Monitoring for Children and Adolescents on Antipsychotics- Total	27.76%	10	2	
Follow Up After Hospitalization for mental Illness- 7 Day Follow Up Total	31.45%	25	3	
Initiation and Engagement of AOD use or Dependence Treatment: Initiation Total	40.49%	25	3	

Performance Improvement Project Validation

42 CFR §438.330 (d) and §457.1240 (b)

The validation of the Performance Improvement Projects (PIPs) was conducted in accordance with the protocol developed by CMS titled, "EQR Protocol 1: Validating Performance Improvement Projects, October 2019." The protocol validates components of the project and its documentation to provide an assessment of the overall study design and methodology of the project. The components assessed are as follows:

- Study topic(s)
- Study question(s)
- Study indicator(s)
- Identified study population
- Sampling methodology (if used)
- Data collection procedures
- Improvement strategies

For this review, two PIPs were submitted and validated. Topics for PIPs include Access and Availability to Care and Comprehensive Diabetes Care. *Table 11: Performance Improvement Project Validation Scores* provides an overview of the previous validation scores with the current scores.

Table 11: Performance Improvement Project Validation Scores

Project	Previous Validation Score	Current Validation Score
Access and Availability to Care- Non-Clinical	130/131= 99% High Confidence in Reported Results	100/100= 100% High Confidence in Reported Results

Project	Previous Validation Score	Current Validation Score
Comprehensive Diabetes Care- Clinical	120/126=95% High Confidence in Reported Results	100/100=100% High Confidence in Reported Results

All the PIPs scored in the "High Confidence in Reported Results" range. There are no corrective actions or recommendations. The Access to Care PIP is now closed and a new PIP will be established to replace it.

The recommendations for last year included initiating or revising interventions for the Access and Availability to Care PIP and to continue to monitor the adult access to preventive (AAP) services even with pending closure of the PIP. The PIP document received for this review contained additional measures and data. Staff indicated during the onsite, that the additional information added to the PIP document was to monitor Access in innovative ways, as this PIP is being replaced and will be closed for the subsequent review year.

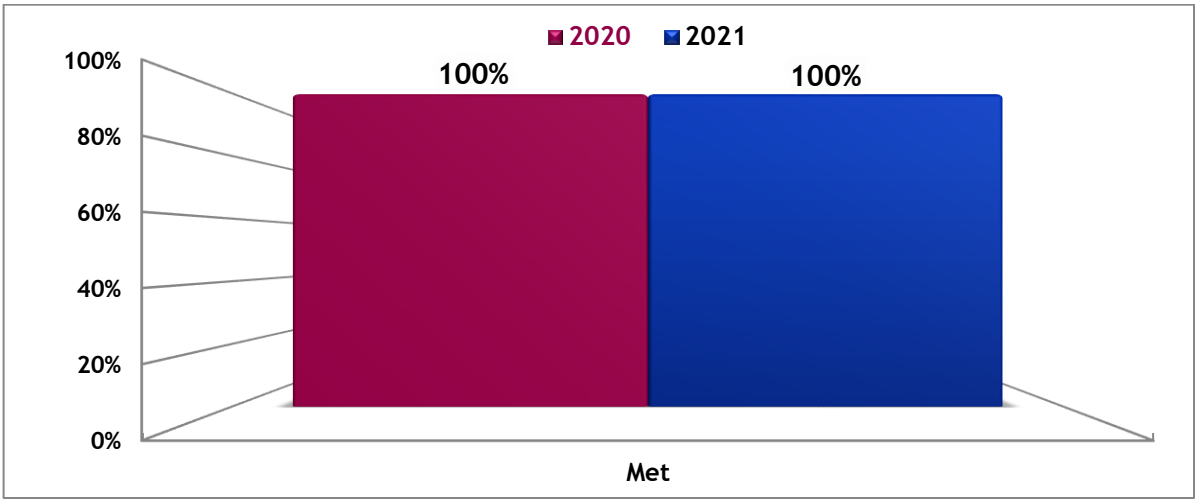
The PIP document showed improvement in the AAP measure although it is still below baseline and the CAHPS indicator improved slightly from the previous remeasurement to 85.32% which is above the 81.97% goal. The other indicators that were added did not have a clear presentation of the indicator definitions, goals, benchmarks, and results were not clearly presented. There were several interventions reported including live outreach phone calls, CAHPS education, care reports to providers, ED diversion program, and hold messaging for call center to remind members about preventive services.

The Comprehensive Diabetes Care PIP showed improvement for the Hemoglobin A1c indicator from 85.16% to 85.86% and eye exam indicator from 36.74% to 41.12% although neither measure has achieved the goal rate. Interventions reported include in home visits, HealthCrowd outreach and event screening, gift card incentives for members, provider coding seminars, and practice consultant onsite visits.

Details of the validation of the performance measures and performance improvement projects can be found in the *CCME EQR Validation Worksheets, Attachment 3*.

Healthy Blue continues to meet all the requirements in the QI section of the review as noted in *Figure 6*.

Figure 6: Quality Improvement Findings



Strengths

- Healthy Blue uses certified software for HEDIS calculations.
- There were no performance measures with a substantial decline of greater than 10%.
- Network providers receive monthly Quality Reports that contain provider specific data regarding assigned members.

Weaknesses

- The reports and information on Healthy Blue's website related to the QI Program was outdated.

Recommendations:

- Update the QI Program documents on the Healthy Blue website with current performance data results.

E. Utilization Management

42 CFR § 438.210(a-e),42 CFR § 440.230, 42 CFR § 438.114, 42 CFR § 457.1230 (d), 42 CFR § 457. 1228, 42 CFR § 438.228,42 CFR § 438, Subpart F, 42 CFR § 457. 1260, 42 CFR § 208, 42 CFR § 457.1230 (c),42 CFR § 208, 42 CFR § 457.1230 (c)

CCME's assessment for Utilization Management (UM) includes UM documents, medical necessity determination processes, pharmacy requirements, the Care Management (CM) Program, and a review of approval, denial, appeal, and care management files. Healthy Blue's UM Program is incorporated within Amerigroup's Health Care Management Division. The Medical Director and Behavioral Health Medical Director provide oversight and expertise over UM activities.

Processes for reviewing service authorization requests are conducted utilizing MCG guidelines, internal clinical criteria, or other established criteria. Healthy Blue assesses consistency in criteria application and decision-making through annual inter-rater reliability testing for physician reviewers and clinical reviewers for medical and behavioral health services. Onsite discussion confirmed all reviewers received passing scores.

Review of approval and denial files reflected timely and consistent decision-making and notification. Approval notices were faxed to the provider and contained all required information. Adverse benefit determination notices were written in clear language for a layperson to understand.

The Pharmacy Services Program, managed by IngenioRx, uses the most current version of the preferred drug list (PDL) to fulfill pharmacy requirements. The PDL and a PDL updates log are maintained on the website.

Healthy Blue's approach to care management processes is outlined in the Population Health Program Description and the Care Management Program Description. Healthy Blue has documented methods for identifying and referring members into various CM programs to ensure comprehensive, coordinated care for members. Members are stratified into appropriate risk levels and intervention groups. Additionally, processes are in place to address Transitional Care Management requirements as defined in the *SCDHHS Contract, Section 5.6*. CM files indicate care management activities are conducted by licensed clinical professionals, as stated in policies such as SC_CAXX_106, Case Management Documentation and the Case Manager Role and Function in Complex Case Management.

Healthy Blue analyzed and monitored utilization data for several services such as emergency room visits and inpatient setting discharges. Results are reported during applicable committee meetings.

The UM Program is evaluated at least annually to assess its strengths and effectiveness. Results are reported to the CQIC and SQIC. Additionally, CCME identified that Healthy Blue has implemented several recommendations made from the 2020 EQR.

Appeals

42 CFR § 438.228,42 CFR § 438, Subpart F, 42 CFR § 457.1260

Healthy Blue has policies describe processes for handling appeals of adverse benefit determinations. Definitions of terminology such as "adverse benefit determination" and "appeal," as well as who may file an appeal, are correctly documented. Procedures for filling an appeal are clearly provided and consistently documented in policies, the Member Handbook, Provider Manual, and on the website. However, appeals information

on the website is listed under headings that do not clearly convey or identify that appeals information is located there, which may be a barrier for members who want to file an appeal.

Review of appeal files reflected timely acknowledgement, resolution, and notification of determination. Determination letters are written in language that is easily understood by a layperson and instructions for State Fair Hearings are provided. However, staff did not consistently follow appeals process outlined in Policy SC_GAXX_051, Member Appeal Process. CCME identified that appeal case file letters did not include the 10-day timeframe when members had to respond with new evidence, appeal case file letters were not mailed to members within 10 days of the plan receiving the appeals request, and member consent was not consistently obtained.

As noted in *Figure 7: Utilization Management Findings*, Healthy Blue achieved "Met" scores for 98% of the UM standards and 2% of the standards were scored as "Partially Met."

Figure 7: Utilization Management Findings

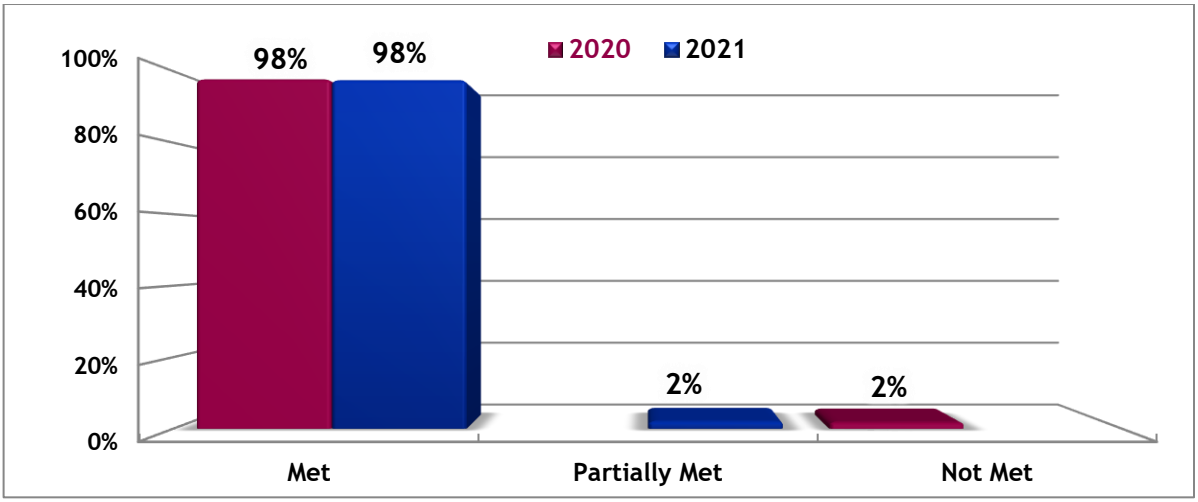


TABLE 12: Utilization Management Comparative Data

SECTION	STANDARD	2020 REVIEW	2021 REVIEW
Appeals	The MCO applies the appeal policies and procedures as formulated.	Not Met	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2020 to 2021.

Strengths

- All required forms for abortions, hysterectomies, and sterilizations are available on the website.

Weaknesses

- Appeals information is listed under headings on the website that do not clearly convey or identify that appeals information is located there, which can be a barrier for members who want to file an appeal.
- The following issues were noted with processing appeals, according to processes outlined in Policy SC_GAXX_051, Member Appeal Process:
  - Two versions of appeal case file letters were utilized; an updated version instructed members to respond with additional information within 10 calendar days from the date on the letter and the other version did not provide a timeframe to respond.
  - Appeal case files were not sent to members within 10 calendar days, not allowing adequate time for the member to respond prior to the determination.
  - Staff were not consistent with obtaining member consent when an appeal was requested from a provider.
- Responsibilities of the Transition Coordinator are not indicated in the Population Health Program Description and Complex Case Management Program Descriptions.

Quality Improvement Plans

- Follow processes in Policy SC_GAXX_051, Member Appeal Process, to ensure appeal case file letters are mailed to members within 10 days of receiving the appeal request and to ensure member consent is obtained when an appeal is requested from a someone other than the member.

Recommendations

- Provide appeal information on the website in a manner that is clearly recognizable and in a location that can be easily accessed, such as under the “grievance and appeals” tab.
- Ensure updated appeal case file letters, with the 10-day response timeframe, are utilized when processing member appeal requests, allowing members at least 10 calendar days to respond to the plan.
- Update the Population Health Program Description and the Complex Case Management Program Description to include a description indicating the Care Management Manager is the designated Transition Coordinator who is responsible for oversight of transition of care activities.

F. Delegation

42 CFR § 438.230 and 42 CFR § 457.1233(b)

Delegation agreements are in place between Healthy Blue/Amerigroup and the entities listed in *Table 13: Delegated Entities and Services*.

Table 13: Delegated Entities and Services

Delegated Entities	Delegated Services
AnMed Health SC Department of Mental Health MUSC Prisma Health Midlands Prisma Health Upstate Regional Health Plus Roper St. Francis Vision Service Plan	Credentialing and Recredentialing
IngenioRx CVS Caremark	Pharmacy Benefit Management
AIM Specialty Health	Call Center and Utilization Management
CulturaLink CyraCom International, Inc	Translation Services

Processes and requirements for delegation of health plan activities are found in the Delegate/Vendor Oversight and Management Program, Policy MCD-10, Credentialing Delegation, Policy A65 - Pharmacy Benefit Manager Performance Oversight, and a policy titled, "Utilization Management - Medicaid Delegation and Oversight."

Pre-delegation assessment activities are conducted to ensure proposed delegates can meet established contractual and applicable federal, state, and accreditation standards. During the pre-delegation assessment, the proposed delegate's internal organizational structure and compliance with applicable contracted activities, plans/programs, and other processes is assessed. Once delegation is approved, an agreement that describes the scope, functions, activities, and roles, and responsibilities of both the health plan and the delegate is executed.

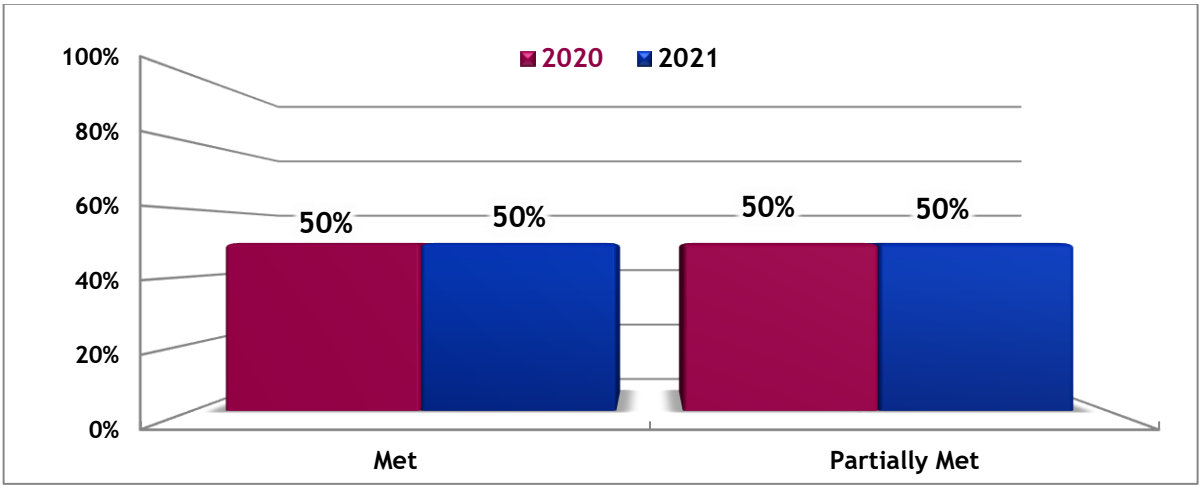
Annual oversight is conducted of each delegate. The annual review includes an assessment of the delegate's compliance with accreditation standards, contractual requirements, written policies and procedures, and quality activities related to the delegated activities. For utilization and credentialing/recredentialing activities, the annual oversight includes file review to assess the delegate's compliance with

contractual requirements, state and federal regulations, and accreditation standards. In addition to annual oversight, delegates provide reports of delegated activities to the health plan on a predetermined schedule. If any deficiencies are identified, a corrective action process is initiated, and the delegate is informed in writing of the corrective action required and the timeframe for completion.

Documentation of delegation oversight was submitted for review. Issues were identified related to lack of documentation on the MCO Credentialing File Review Workbook tool related to verification of the National Plan and Provider Enumeration System, a repeat finding from the previous EQR, and the Social Security Death Master File. Additionally, the tool did not indicate collection of nurse practitioner collaborative agreements was verified.

As noted in *Figure 8: Delegation Findings*, 50% of the Delegation standards were scored as "Met."

Figure 8: Delegation Findings



Weaknesses

- Documentation of delegation oversight was submitted for review. The following issues were identified:
  - For two delegates, the MCO Credentialing File Review Workbook does not indicate whether the delegates were monitored for querying the National Plan and Provider Enumeration System, as stated in Policy MCD-10, Medicaid Delegated Credentialing. This is a repeat finding from the previous EQR.
  - For one delegate, the MCO Credentialing File Review Workbook does not indicate whether the delegate was monitored for querying the Social Security Death Master File, as stated in Policy MCD-10, Medicaid Delegated Credentialing.

- For five credentialing delegates, the MCO Credentialing File Review Workbook does not indicate whether the delegates were monitored for collection of nurse practitioner collaborative agreements.

Quality Improvement Plans

- Ensure credentialing and recredentialing delegates are monitored for conducting required queries of the National Plan and Provider Enumeration System and Social Security Death Master File, as well as collection of collaborative agreements between nurse practitioners and supervising physicians. This should be documented in the MCO Credentialing File Review Workbook used to assess credentialing delegates.

G. State Mandated Services

42 CFR Part 441, Subpart B

Healthy Blue's EPSDT Program follows the American Academy of Pediatrics periodicity schedule for required screenings and services. The plan monitors compliance with immunization and EPSDT requirements by conducting activities such as reviewing PCP rates for immunization and well-child visits and through random medical record reviews conducted by the Quality Improvement Department. Additionally, Healthy Blue provides all core benefits specified by the *SCDHHS Contract*.

During onsite discussions, Healthy Blue staff reported that several state-of-emergency restrictions and guidelines related to the COVID-19 pandemic in 2020 may have contributed to pediatric provider compliance with performing EPSDT/ Well Child visits and immunizations. The staff will consider conducting a performance improvement project related to developmental screenings to assist members with obtaining required EPSDT and immunization services.

A Quality Improvement Plan deficiency from the 2020 EQR relating to documentation of oversight of credentialing delegates was not corrected. Thus, Healthy Blue continues to receive a "Not Met" score for not addressing deficiencies identified in the previous EQR.

As indicated in *Figure 9: State Mandated Services*, standards in the State Mandated Services section are scored as 75% "Met" and 25% "Not Met."

Figure 9: State Mandated Services

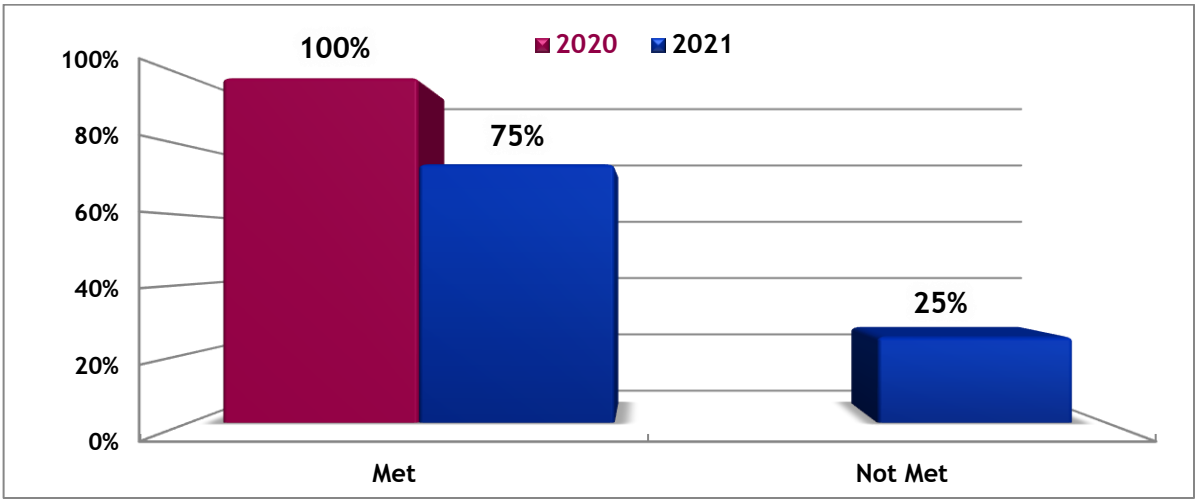


TABLE 14: State Mandated Comparative Data

SECTION	STANDARD	2020 REVIEW	2021 REVIEW
State Mandated Services	The MCO addresses deficiencies identified in previous independent external quality reviews.	Met	Not Met

The standards reflected in the table are only the standards that showed a change in score from 2020 to 2021.

Strengths

- Healthy Blue follows the EPSDT periodicity schedule according to the American Academy of Pediatrics.

Weaknesses

- As identified in the 2020 EQR, the current EQR found that documentation of oversight of credentialing delegates did not indicate whether the delegates were monitored for querying the National Plan and Provider Enumeration System.

Quality Improvement Plans

- Implement quality improvement plans from the EQR to address all identified deficiencies.

ATTACHMENTS

- Attachment 1: Initial Notice, Materials Requested for Desk Review
- Attachment 2: Materials Requested for Onsite Review
- Attachment 3: EQR Validation Worksheets
- Attachment 4: Tabular Spreadsheet

A. Attachment 1: Initial Notice, Materials Requested for Desk Review

March 15, 2021

Mr. Christopher Teska
Assistant Vice President for Medicaid
Healthy Blue
PO Box 6170, Mail Code AX-400
Columbia, SC 29260-6170

Dear Mr. Teska:

At the request of the South Carolina Department of Health and Human Services (SCDHHS) this letter serves as notification that the 2021 External Quality Review (EQR) of Healthy Blue is being initiated. An external quality review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) is required by your contract with SCDHHS in relation to your organization's administration of a managed care program for the Healthy Connections Medicaid recipients.

The methodology used by CCME to conduct this review will follow the protocols developed by the Centers for Medicare and Medicaid Services (CMS) for external quality review of Medicaid Managed Care Organizations. As required by these protocols, the review will include both a desk review (at CCME), Onsite visit and will address all contractually required services as well as follow up of any areas of weakness identified during the previous review. Due to COVID-19 the two day onsite previously performed at the health plan's office will be conducted virtually. The CCME EQR team plans to conduct the virtual onsite on **June 2nd and 3rd**.

In preparation for the desk review, the items on the enclosed desk materials list should be provided to CCME no later than **March 29, 2021.**

To help with submission of the desk materials, we have set-up a secure file transfer site to allow health plans under review to submit desk materials directly to CCME thru the site. The file transfer site can be found at:

https://eqro.thecarolinascenter.org

I have included written instructions on how to use the file transfer site and would be happy to answer any questions on how to utilize the file transfer site if needed. An opportunity for a conference call with your staff, to describe the review process and answer any questions prior to the onsite visit, is being offered as well. Please contact me directly at sowens@thecarolinascenter.org if you would like to schedule time for either of these conversational opportunities.

Thank you and we look forward to working with you.

Sincerely,

Sandi Owens

Sandi Owens, LPN
Manager, External Quality Review

Enclosure
cc: SCDHHS

External Quality Review 2021

MATERIALS REQUESTED FOR DESK REVIEW

1. Copies of all current policies and procedures, as well as a complete index which includes policy name, number and department owner. The date of the addition/review/revision should be identifiable on each policy.

2. Organizational chart of all staff members including names of individuals in each position, and any current vacancies.

3. Current membership demographics including total enrollment and distribution by age ranges, sex, and county of residence.

4. Documentation of all service planning and provider network planning activities (e.g., copies of complete geographic assessments, provider network assessments, enrollee demographic studies, and population needs assessments) that support the adequacy of the provider base. Please include the maximum allowed and the current member-to-PCP ratios and member-to-specialist ratios.

5. A complete list of network providers for the Healthy Connections Choices (HCC) members. **The list should be submitted as an excel spreadsheet in the format listed in the table below**. Specialty codes and county codes may be used however please provide an explanation of the codes used by your organization.

Excel Spreadsheet Format

List of Network Providers for Healthy Connections Choices Members	
Practitioner's First Name	Practitioner's Last Name
Practitioner's title (MD, NP, PA, etc.)	Phone Number
Specialty	Counties Served
Practice Name	Indicate Y/N if provider is accepting new patients
Practice Address	Age Restrictions

6. The total number of unique specialty providers as well as the total number of unique primary care providers currently in the network.

7. A current provider list/directory as supplied to members.

8. A copy of the current Compliance plan and organization chart for the compliance department. Include the Fraud, Waste, and Abuse plan if a separate document has been developed, as well as any policies/procedures related to provider payment suspensions and recoupments of overpayments, and the pharmacy lock-in program.

9. A description of the Credentialing, Quality Improvement, Medical/Utilization Management, Disease/Case Management, and Pharmacy Programs.

10. The Quality Improvement work plans for 2020 and 2021.

11. The most recent reports summarizing the effectiveness of the Quality Improvement, Medical/Utilization Management, and Disease/Case Management Programs.

12. Documentation of all Performance Improvement Projects (PIPs) completed or planned since the previous Annual Review, and any interim information available for those projects currently in progress. This documentation should include information from the project that explains and documents all aspects of the project cycle (i.e. analytic plans, reasons for choosing the topic, measurement definitions, interventions planned or implemented, calculated results, analysis of results for each measurement period, barriers to improvement and interventions to address each barrier, statistical analysis (if sampling was used), etc.

13. Minutes of all committee meetings in the past year reviewing or taking action on SC Medicaid-related activities. All relevant attachments (e.g., reports presented, materials reviewed) should be included. If attachments are provided as part of another portion of this request, a cross-reference is satisfactory, rather than sending duplicate materials.

14. Membership lists and a committee matrix for all committees including the professional specialty of any non-staff members. Please indicate which members are voting members and include the committee charters if available.

15. Any data collected for the purposes of monitoring the utilization (over and under) of health care services.

16. Copies of the most recent physician profiling activities conducted to measure contracted provider performance.

17. Results of the most recent medical office site reviews, medical record reviews and a copy of the tools used to complete these reviews.

18. A complete list of all members enrolled in the case management program from April 2020 through March 2021. Please include open and closed case management files, the member's name, Medicaid ID number, and condition or diagnosis which triggered the need for case management.

19. A copy of staff handbooks/training manuals, orientation and educational materials and scripts used by Member Services Representatives and/or Call Center personnel.

20. A copy of the member handbook and any statement of the member bill of rights and responsibilities if not included in the handbook.

21. A report of findings from the most recent member and provider satisfaction survey, a copy of the tool and methodology used. If the survey was performed by a subcontractor, please include a copy of the contract, final report provided by the subcontractor, and other documentation of the requested scope of work.

22. A copy of any member and provider newsletters, educational materials and/or other mailings. Include new provider orientation and ongoing provider education materials.

23. A copy of the Grievance, Complaint and Appeal logs for the months of April 2020 through March 2021.

24. Copies of all letter templates for documenting approvals, denials, appeals, grievances and acknowledgements.

25. Service availability and accessibility standards and expectations, and reports of any assessments made of provider and/or internal MCO compliance with these standards.

26. Preventive health practice guidelines recommended by the MCO for use by practitioners, including references used in their development, when they were last updated, how they are disseminated and how consistency with other MCO services and covered benefits is assessed.

27. Clinical practice guidelines for disease and chronic illness management recommended by the MCO for use by practitioners, including references used in their development, when they were last updated, how they are disseminated and how consistency with other MCO services and covered benefits is assessed.

28. A list of physicians currently available for utilization consultation/review and their specialty.

29. A copy of the provider handbook or manual.

30. A sample provider contract.

31. Documentation supporting requirements included in the Information Systems Capabilities Assessment for Managed Care Organizations (ISCAs). Please provide the following:
    a. A completed ISCA. *(Not a summarized ISCA or a document that contains ISCA-like information, but the ISCA itself.)*
    b. A network diagram showing (at a minimum) the relevant components in the information gathering, storage, and analysis processes. *(We are interested in the processing of claims and data in South Carolina, so if the health plan in South Carolina is part of a larger organization, the emphasis or focus should be on the network resources that are used in handling South Carolina data.)*
    c. A flow diagram or textual description of how data moves through the system. *(Please see the comment on b. above.)*
    d. A copy of the IT Disaster Recovery Plan or Business Continuity Plan.
    e. A copy of the most recent disaster recovery or business continuity plan test results.
    f. An organizational chart for the IT/IS department and a corporate organizational chart that shows the location of the IT organization within the corporation.
    g. A copy of the most recent data security audit, if completed.
    h. A copy of the policies or program description that address the information systems security and access management. Please also include polices with respect to email and PHI.
    i. A copy of the Information Security Plan & Security Risk Assessment.
    j. A copy of the claims processing monitoring reports covering the period of April 2020 through March 2021.

32. A listing of all delegated activities, the name of the subcontractor(s), methods for oversight of the delegated activities by the MCO, and any reports of activities submitted by the subcontractor to the MCO.

33. Sample contract used for delegated entities. Include a sample contract for each type of service delegated; i.e. credentialing, behavioral health, utilization management, external review, case/disease management, etc. Specific written agreements with subcontractors may be requested at the onsite review at CCME's discretion.

34. Results of the most recent monitoring activities for all delegated activities. Include a full description of the procedure and/or methodology used and a copy of any tools used.

35. All HEDIS data and other performance and quality measures collected or planned. Required data and information include the following:
    a. final HEDIS audit report
    b. data collection methodology used (e.g., administrative data, including sources; medical record review, including how records were identified and how the sample was chosen; hybrid methodology, including data sources and how the sample was chosen; or survey, including a copy of the tool, how the sample was chosen and how the data was input), including a full description of the procedures;
    c. reporting frequency and format;
    d. specifications for all components used to identify the eligible population (e.g., member ID, age, sex, continuous enrollment calculation, clinical ICD/CPT codes, member months/years calculation, other specified parameters);
    e. programming specifications that include data sources such as files/databases and fields with definitions, programming logic and computer source codes;
    f. denominator calculations methodology, including:
        1) data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy files, enrollment files, etc.);
        2) specifications for all components used to identify the population for the denominator;
    g. numerator calculations methodology, including:
        1) data sources used to calculate the numerator (e.g., claims files, medical records, provider files, pharmacy files, enrollment files, etc.);
        2) specifications for all components used to identify the population for the numerator;
    h. calculated and reported rates. Please include the Quality Compass percentile, point value, and index scores for the SCDHHS withhold measures.

36. Provide electronic copies of the following files:
    a. Credentialing files for:
        i. Ten PCP's (Include two NP's acting as PCP's, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two behavioral health providers;
        v. Two network hospitals; and
        vi. One file for each additional type of facility in the network.
    b. Recredentialing files for:
        i. Ten PCP's (Include two NP's acting as PCP's, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two behavioral health providers
        v. Two network hospitals; and
        vi. One file for each additional type of facility in the network.
    c. Twenty medical necessity denial files (acute inpatient, outpatient and behavioral health) made in the months of April 2020 through March 2021. Include any medical information and physician review documentations used in making the denial determination.
    d. Twenty-five utilization approval files (acute inpatient, outpatient and behavioral health) made in the months of April 2020 through March 2021, including any medical information and approval criteria used in the decision. Please include prior

authorizations for surgery and/or hospital admissions, concurrent stay, and retrospective review of admissions and of emergency care.

Note: Appeals, Grievances, and Care Coordination/Case Management files will be selected from the logs received with the desk materials. A request will then be sent to the plan to send electronic copies of the files to CCME.

These materials:

- **should be organized and uploaded to the secure CCME EQR File Transfer site at:** https://egro.thecarolinascenter.org

B. Attachment 2: Materials Requested for Onsite Review

External Quality Review 2021

MATERIALS REQUESTED FOR ONSITE REVIEW

1. Copies of all committee minutes for committees that have met since the desk materials were submitted.
2. The most recent Geo Access reports measuring access for specialists within the network.
3. The Healthy Blue Practitioner Access Analysis for calendar year 2020.
4. See the list of missing information in the credentialing and recredentialing files.
5. CAHPS Child CCC Summary Report from DSS Research.
6. RY2020 Over and Under Utilization Reports in draft or final format.

C. Attachment 3: EQR Validation Worksheets

CCME EQR PIP Validation Worksheet

Plan Name:	**Healthy Blue**
Name of PIP:	**ACCESS TO CARE**
Reporting Year:	2020
Review Performed:	2021

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Data analysis and study rationale are reported.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aim is reported.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	Addresses key aspects of enrollee care and service.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	PIP includes all enrollees in relevant population.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**MET**	Sampling technique followed HEDIS guidelines.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**MET**	Methods are used to mitigate bias.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**MET**	Sufficient sample, based on HEDIS methodology, was used.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measures are defined.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicators are related to functional status and processes of care.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data collection methods are documented.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Data sources are documented.

Component / Standard (Total Points)	Score	Comments
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Data is collected using programming logic.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instrument reports are documented.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan noted as annual.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Staff for data collection and project analysis are documented.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Annual rates are reported and additional data for access was monitored before closing the PIP.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented using tables.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and several repeat measurements are presented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data included rate evaluation over a few remeasurements.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers are reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	The rates for Access to Care have been monitored, and although rates improved for the primary indicators, the indicators are still below goal rate. PIP is being replaced.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Improvement appears to be related to the interventions.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	Z score results are presented.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Goal rates were not attained for APP; CAHPS rate was achieved but sustainment was not yet accomplished.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

Steps	Possible Score	Score
Step 1		
1.1	5	5
Step 2		
2.1	10	10
Step 3		
3.1	1	1
3.2	1	1
Step 4		
4.1	5	5
4.2	10	10
4.3	5	5
Step 5		
5.1	10	10
5.2	1	1
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	5	5
7.2	10	10
7.3	1	1
7.4	1	1
Step 8		
8.1	10	10
Step 9		
9.1	1	1
9.2	5	5
9.3	1	1
9.4	NA	NA

Project Score	100
Project Possible Score	100
Validation Findings	100%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

Audit Designation Categories	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. *Validation findings must be 90%–100%.*
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. *Validation findings must be 70%–89%.*
Low Confidence in Reported Results	Plan deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. *Validation findings between 60%–69% are classified here.*
Reported Results NOT Credible	Major errors that put the results of the entire project in question. *Validation findings below 60% are classified here.*

CCME EQR PIP Validation Worksheet

Plan Name:	**Healthy Blue**
Name of PIP:	**COMPREHENSIVE DIABETES CARE**
Reporting Year:	2020
Review Performed:	2021

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Data analysis and study rationale are reported.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aim is reported.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	Addresses key aspects of enrollee care and service.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	PIP includes all enrollees in relevant population.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**MET**	Sampling technique followed HEDIS guidelines.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**MET**	Methods are used to mitigate bias.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**MET**	Sufficient sample, based on HEDIS methodology, was used.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measures are defined.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicators are related to functional status and processes of care.

Component / Standard (Total Points)	Score	Comments
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data collection methods are documented.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Data sources are documented.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Data is collected using programming logic.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instrument reports are documented.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan noted as annual.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Staff for data collection and project analysis are documented.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Annual rates are reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented using tables.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and several repeat measurements are presented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data included rate evaluation over a few remeasurements.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers are reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	The rates improved for A1C screening from 85.16% to 86.86% and the eye exam rate improved from 36.74% to 41.12% in the most recent remeasurement.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Improvement appears to be related to the provider coding, onsite visits when allowed, in home visits when allowed, event screenings, and HealthCrowd campaign.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	Z score results are presented.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

Steps	Possible Score	Score
Step 1		
1.1	5	5
Step 2		
2.1	10	10
Step 3		
3.1	1	1
3.2	1	1
Step 4		
4.1	5	5
4.2	10	10
4.3	5	5
Step 5		
5.1	10	10
5.2	1	1
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	5	5
7.2	10	10
7.3	1	1
7.4	1	1
Step 8		
8.1	10	10
Step 9		
9.1	1	1
9.2	5	5
9.3	1	1
9.4	NA	NA

Project Score	**100**
Project Possible Score	**100**
Validation Findings	**100%**

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

Audit Designation Categories	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. *Validation findings must be 90%–100%.*
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. *Validation findings must be 70%–89%.*
Low Confidence in Reported Results	Plan deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. *Validation findings between 60%–69% are classified here.*
Reported Results NOT Credible	Major errors that put the results of the entire project in question. *Validation findings below 60% are classified here.*

CCME EQR PM Validation Worksheet

Plan Name:	**Healthy Blue**
Name of PM:	**ALL HEDIS MEASURES**
Reporting Year:	**2019 (HEDIS 2020)**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
HEDIS 2020 ***(Note: Due to COVID allowances, hybrid rates for HEDIS2020 were rotated)***

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**Met**	Data sources and programming logic were documented.

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**Met**	Denominator sources were accurate.
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	Calculation of rates adhered to denominator specifications.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	Numerator sources were accurate.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	Calculation of rates adhered to numerator specifications.
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Met**	Documentation and tools were found to be compliant.
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Met**	Integration methods were found to be compliant.
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**Met**	Methods were reported to be compliant.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**Met**	Sampling was conducted according to specifications.
S2 Sampling	Sample size and replacement methodologies met specifications.	**Met**	Replacements were conducted and found compliant.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	HEDIS specifications were followed and found compliant.
Overall assessment			Plan uses NCQA certified software applications: Quality Spectrum Insight™ from Inovalon and Cotiviti. Audit report noted compliance for HEDIS measures.

VALIDATION SUMMARY			
Element	**Standard Weight**	**Validation Result**	**Score**
G1	10	Met	10
D1	10	Met	10
D2	5	Met	5
N1	10	Met	10
N2	5	Met	5
N3	5	Met	5
N4	5	Met	5
N5	5	Met	5
S1	5	Met	5
S2	5	Met	5
R1	10	Met	10

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

CCME EQR Survey Validation Worksheet

Plan Name	**Healthy Blue**
Survey Validated	**CAHPS MEMBER SATISFACTION- ADULT**
Validation Period	2020
Review Performed	2021

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted since the lack of information is relevant to the assessment of that activity. (Updated based on October 2019 version of EQR protocol 6)

ACTIVITY 1: REVIEW SURVEY PURPOSE(S), OBJECTIVE(S) AND AUDIENCE

Survey Element		Element Met / Not Met	Comments and Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	Survey purpose documented in the report. *Documentation:* CSS Adult CAHPS Summary Report 2020
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Study objective is documented in the report. *Documentation:* CSS Adult CAHPS Summary Report 2020
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Survey audience is identified in the report. *Documentation:* CSS Adult CAHPS Summary Report 2020

ACTIVITY 2: REVIEW THE RELIABILITY AND VALIDITY OF THE SURVEY INSTRUMENT

Survey Element		Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey was tested for face validity and content validity and found to be valid	**MET**	Survey has been tested for validity. *Documentation:* CSS Adult CAHPS Summary Report 2020
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	**MET**	Survey has been tested for reliability. *Documentation:* CSS Adult CAHPS Summary Report 2020

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Study population was identified. *Documentation:* CSS Adult CAHPS Summary Report 2020
3.2	Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives.	**MET**	Sampling frame was clearly defined and appropriate. *Documentation:* CSS Adult CAHPS Summary Report 2020
3.3	Review that the sampling method appropriate to the survey purpose.	**MET**	Sampling method was conducted according to specifications. *Documentation:* CSS Adult CAHPS Summary Report 2020
3.4	Review whether the sample size is sufficient for the intended use of the survey.	**MET**	Sample size was sufficient according to CAHPS survey guidelines. *Documentation:* CSS Adult CAHPS Summary Report 2020
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Procedures to select the sample were appropriate. *Documentation:* CSS Adult CAHPS Summary Report 2020

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments and Documentation
4.1	Review the specifications for calculating response rates to make sure they are in accordance with industry standards.	**MET**	The specifications for response rates are in accordance with standards. *Documentation:* CSS Adult CAHPS Summary Report 2020
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	**MET**	Response rate is reported and bias in generalizability is documented. *Documentation:* CSS Adult CAHPS Summary Report 2020

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits?	**MET**	The quality plan is documented. *Documentation:* CSS Adult CAHPS Summary Report 2020
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the plan. *Documentation:* CSS Adult CAHPS Summary Report 2020

Survey Element		Element Met / Not Met	Comments and Documentation
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	**MET**	Procedures for missing data were developed and applied. *Documentation:* CSS Adult CAHPS Summary Report 2020

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments and Documentation
6.1	Was the survey data analyzed?	**MET**	Survey data were analyzed. *Documentation:* CSS Adult CAHPS Summary Report 2020
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate tests were utilized. *Documentation:* CSS Adult CAHPS Summary Report 2020
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Conclusions were supported by data analysis. *Documentation:* CSS Adult CAHPS Summary Report 2020

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures are in place to address response issues. *Documentation:* CSS Adult CAHPS Summary Report 2020
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The adult surveys also used oversampling but had 185 valid surveys out of 1,755 with a response rate of 10.56%, an 8.7% decreased from last year's response rate of 19.3%. *Documentation:* CSS Adult CAHPS Summary Report 2020 ***Recommendation:*** *Determine if CSS Research can offer other interventions that can be implemented to improve the response rates, above the current methods of oversampling. Continue internal meetings for response rate improvement initiatives.*
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to work plan. *Documentation:* CSS Adult CAHPS Summary Report 2020
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* CSS Adult CAHPS Summary Report 2020

CCME EQR Survey Validation Worksheet

Plan Name	**Healthy Blue**
Survey Validated	**CAHPS MEMBER SATISFACTION- CHILD CCC**
Validation Period	2020
Review Performed	2021

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted since the lack of information is relevant to the assessment of that activity. (Updated based on October 2019 version of EQR protocol 6)

ACTIVITY 1: REVIEW SURVEY PURPOSE(S), OBJECTIVE(S) AND AUDIENCE

Survey Element		Element Met / Not Met	Comments and Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	Survey purpose documented in the report. *Documentation:* CSS Child CCC CAHPS Summary Report 2020
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Study objective is documented in the report. *Documentation:* CSS Child CCC CAHPS Summary Report 2020
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Survey audience is identified in the report. *Documentation:* CSS Child CCC CAHPS Summary Report 2020

ACTIVITY 2: REVIEW THE RELIABILITY AND VALIDITY OF THE SURVEY INSTRUMENT

Survey Element		Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey was tested for face validity and content validity and found to be valid	**MET**	Survey has been tested for validity. *Documentation:* CSS Child CCC CAHPS Summary Report 2020
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	**MET**	Survey has been tested for reliability. *Documentation:* CSS Child CCC CAHPS Summary Report 2020

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Study population was identified. *Documentation:* CSS Child CCC CAHPS Summary Report 2020
3.2	Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives.	**MET**	Sampling frame was clearly defined and appropriate. *Documentation:* CSS Child CCC CAHPS Summary Report 2020
3.3	Review that the sampling method appropriate to the survey purpose	**MET**	Sampling method was conducted according to specifications. *Documentation:* CSS Child CCC CAHPS Summary Report 2020
3.4	Review whether the sample size is sufficient for the intended use of the survey.	**MET**	Sample size was sufficient according to CAHPS survey guidelines. *Documentation:* CSS Child CCC CAHPS Summary Report 2020
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Procedures to select the sample were appropriate. *Documentation:* CSS Child CCC CAHPS Summary Report 2020

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments and Documentation
4.1	Review the specifications for calculating response rates to make sure they are in accordance with industry standards	**MET**	The specifications for response rates are in accordance with standards. *Documentation:* CSS Child CCC CAHPS Summary Report 2020
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	**MET**	Response rate is reported and bias in generalizability is documented. *Documentation:* CSS Child CCC CAHPS Summary Report 2020

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	The quality plan is documented. *Documentation:* CSS Child CCC CAHPS Summary Report 2020
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the plan. *Documentation:* CSS Child CCC CAHPS Summary Report 2020

Survey Element		Element Met / Not Met	Comments and Documentation
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	**MET**	Procedures for missing data were developed and applied. *Documentation:* CSS Child CCC CAHPS Summary Report 2020

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments and Documentation
6.1	Was the survey data analyzed?	**MET**	Survey data were analyzed. *Documentation:* CSS Child CCC CAHPS Summary Report 2020
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate tests were utilized. *Documentation:* CSS Child CCC CAHPS Summary Report 2020
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Conclusions were supported by data analysis. *Documentation:* CSS Child CCC CAHPS Summary Report 2020

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures are in place to address response issues. *Documentation:* CSS Child CCC CAHPS Summary Report 2020
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The CCC survey sample was below the target of N=411 with 217 completed surveys out of 2,145 for a response rate of 10.12% (even with oversampling of 30%). This is a decline from the 19% response rate in the previous review. *Documentation:* CSS Child CCC CAHPS Summary Report 2020 ***Recommendation:*** *Determine if CSS Research can offer other interventions that can be implemented to improve the Child (CCC) general population response rates, above the current methods of oversampling. Continue internal meetings for response rate improvement initiatives.*
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to work plan. *Documentation:* CSS Child CCC CAHPS Summary Report 2020
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* CSS Child CCC CAHPS Summary Report 2020

CCME EQR Survey Validation Worksheet

Plan Name	**Healthy Blue**
Survey Validated	**CAHPS MEMBER SATISFACTION- CHILD**
Validation Period	2020
Review Performed	2021

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted since the lack of information is relevant to the assessment of that activity. (Updated based on October 2019 version of EQR protocol 6)

ACTIVITY 1: REVIEW SURVEY PURPOSE(S), OBJECTIVE(S) AND AUDIENCE

Survey Element		Element Met / Not Met	Comments and Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	Survey purpose documented in the report. *Documentation:* CSS Child CAHPS Summary Report 2020
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Study objective is documented in the report. *Documentation:* CSS Child CAHPS Summary Report 2020
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Survey audience is identified in the report. *Documentation:* CSS Child CAHPS Summary Report 2020

ACTIVITY 2: REVIEW THE RELIABILITY AND VALIDITY OF THE SURVEY INSTRUMENT

Survey Element		Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey was tested for face validity and content validity and found to be valid.	**MET**	Survey has been tested for validity. *Documentation:* CSS Child CAHPS Summary Report 2020
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable.	**MET**	Survey has been tested for reliability. *Documentation:* CSS Child CAHPS Summary Report 2020

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Study population was identified. *Documentation:* CSS Child CAHPS Summary Report 2020
3.2	Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives.	**MET**	Sampling frame was clearly defined and appropriate. *Documentation:* CSS Child CAHPS Summary Report 2020
3.3	Review that the sampling method appropriate to the survey purpose.	**MET**	Sampling method was conducted according to specifications. *Documentation:* CSS Child CAHPS Summary Report 2020
3.4	Review whether the sample size is sufficient for the intended use of the survey.	**MET**	Sample size was sufficient according to CAHPS survey guidelines. *Documentation:* CSS Child CAHPS Summary Report 2020
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Procedures to select the sample were appropriate. *Documentation:* CSS Child CAHPS Summary Report 2020

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments and Documentation
4.1	Review the specifications for calculating response rates to make sure they are in accordance with industry standards.	**MET**	The specifications for response rates are in accordance with standards. *Documentation:* CSS Child CAHPS Summary Report 2020
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	**MET**	Response rate is reported and bias in generalizability is documented. *Documentation:* CSS Child CAHPS Summary Report 2020

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits?	**MET**	The quality plan is documented. *Documentation:* CSS Child CAHPS Summary Report 2020
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the plan. *Documentation:* CSS Child CAHPS Summary Report 2020

Survey Element		Element Met / Not Met	Comments and Documentation
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	**MET**	Procedures for missing data were developed and applied. *Documentation:* CSS Child CAHPS Summary Report 2020

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments and Documentation
6.1	Was the survey data analyzed?	**MET**	Survey data were analyzed. *Documentation:* CSS Child CAHPS Summary Report 2020
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate tests were utilized. *Documentation:* CSS Child CAHPS Summary Report 2020
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Conclusions were supported by data analysis. *Documentation:* CSS Child CAHPS Summary Report 2020

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures are in place to address response issues. *Documentation:* CSS Child CAHPS Summary Report 2020
7.2	Do the survey findings have any limitations or problems with generalization of the results?	Even with oversampling, the child surveys did not meet the minimum sample size of 411 valid surveys with a total of 192 completed out of 2,145 and the response rate was 8.96%, which is an 8.7% decrease from the 17.7% rate last year. *Documentation:* CSS Child CAHPS Summary Report 2020 ***Recommendation:*** *Determine if CSS Research can offer other interventions that can be implemented to improve the child response rates, above the current methods of oversampling. Continue internal meetings for response rate improvement initiatives.*
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to work plan. *Documentation:* CSS Child CAHPS Summary Report 2020
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* CSS Child CAHPS Summary Report 2020

D. Attachment 4: Tabular Spreadsheet

The Carolinas Center *for* Medical Excellence

CCME MCO Data Collection Tool

Plan Name:	Healthy Blue
Collection Date:	2021

I. ADMINISTRATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I. ADMINISTRATION						
I A. General Approach to Policies and Procedures						
1. The MCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly.	X					Healthy Blue has policies and procedures in place to guide daily operations within the local, state, and federal standards. All policies are located on a shared drive, and a Compliance Newsletter that includes a policy section is sent out to staff.
I B. Organizational Chart / Staffing						
1. The MCO's resources are sufficient to ensure that all health care products and services required by the State of South Carolina are provided to members. At a minimum, this includes designated staff performing in the following roles:						Explanations were provided during the onsite discussion specific to key administrative positions filled by interim staff at the time of the EQR review.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.1 *Administrator (Chief Executive Officer (CEO), Chief Operations Officer (COO), Executive Director (ED));	X					Tim Vaughn is Healthy Blue's President and Chief Executive Officer.
1.2 Chief Financial Officer (CFO);	X					The Chief Financial Officer is Jennifer Thorne.
1.3 * Contract Account Manager;	X					Amy Bennett is the Senior Director, Contract Account Manager/Interagency Liaison.
1.4 Information Systems Personnel;						
1.4.1 Claims and Encounter Manager/ Administrator,	X					Leslie Langslow is the Director II, Claims and Encounter Manager/Administrator.
1.4.2 Network Management Claims and Encounter Processing Staff,	X					
1.5 Utilization Management (Coordinator, Manager, Director);	X					Patt Bliss is the Interim Utilization Manager.
1.5.1 Pharmacy Director,	X					Susan Chavez is the Interim Pharmacy Director.
1.5.2 Utilization Review Staff,	X					Onsite discussion indicated that UM staff work remotely and include both in and out of state employees.
1.5.3 *Case Management Staff,	X					Onsite discussion indicated that CM staff work remotely and include both in and out of state employees.
1.6 *Quality Improvement (Coordinator, Manager, Director);	X					Shana Hunter is the Director Quality Management.
1.6.1 Quality Assessment and Performance Improvement Staff,	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.7 *Provider Services Manager;	X					Shay Looker is the Provider Services Manager.
1.7.1 *Provider Services Staff,	X					
1.8 *Member Services Manager;	X					The Member Services Manager is Letitia Lindsay.
1.8.1 Member Services Staff,	X					
1.9 *Medical Director;	X					Imtiaz Khan, DO is the Medical Director.
1.10 *Compliance Officer;	X					Billy Quarles is the Director of Compliance and Compliance Officer.
1.10.1 Program Integrity Coordinator;	X					Debra Teeter is the Program Integrity Coordinator.
1.10.2 Compliance /Program Integrity Staff;	X					
1.11 * Interagency Liaison;	X					Amy Bennett is the Senior Director, Contract Account Manager/Interagency Liaison.
1.12 Legal Staff;	X					Melanie Joseph is the Legal Director.
1.13 Board Certified Psychiatrist or Psychologist;	X					Dr. Jorge Hernandez-Chaple is the Behavioral Health Medical Director.
1.14 Post-payment Review Staff.	X					Marcus McCarson is the onsite Post-Payment Reviewer.
2. Operational relationships of MCO staff are clearly delineated.	X					
I C. Management Information Systems *42 CFR § 438.242, 42 CFR § 457.1233 (d)*						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO processes provider claims in an accurate and timely fashion.	X					Healthy Blue's average time for paying claims is 98% in 14 days, and 99% in 90 days. Healthy Blue's ISCA documentation indicates that the MCO is capable of meeting the payment performance required by the *SCDHHS Contract*.
2. The MCO is capable of accepting and generating HIPAA compliant electronic transactions.	X					Electronic Data Interchange (EDI) is used to process claims, and presently 98.14% of claims and encounters are submitted electronically.
3. The MCO tracks enrollment and demographic data and links it to the provider base.	X					Healthy Blue leverages a partner vendor (Amerigroup Partnership Plan, LLC) to collect, manage, and process enrollment data. It was noted that the vendor uses SCDHHS- assigned numbers to uniquely identify enrollees. Finally, the vendor processes state 834 files on a daily basis.
4. The MCO's management information system is sufficient to support data reporting to the State and internally for MCO quality improvement and utilization monitoring activities.	X					Healthy Blue creates HEDIS and HEDIS-like reports using NCQA certified HEDIS software. Data used in the HEDIS software is updated monthly and the MCO reviews HEDIS benchmarks each month to ensure accuracy. Finally, Healthy Blue validates its HEDIS process with multiple audits throughout each year.
5. The MCO has policies, procedures and/or processes in place for addressing data security as required by the contract.	X					Healthy Blue manages data access according to the "minimum access necessary principle" which means only the access necessary for someone to complete their role's tasks will be assigned. Additionally, the organization uses full disk encryption for its endpoints, and the MCO

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						restricts the communication of PII to designated corporate systems.
6. The MCO has policies, procedures and/or processes in place for addressing system and information security and access management.	X					Healthy Blue information systems are maintained and managed in accordance with the MCO's System Development Life Cycle (SDLC). The SDLC requires systems to use antivirus software, have malicious code protection, and security monitoring and alerting. Additionally, the organization prohibits its systems to reside in offshore facilities. Finally, Healthy Blue reviews its SDLC annually to ensure it addresses new/changed vulnerabilities and regulatory compliance.
7. The MCO has a disaster recovery and/or business continuity plan that has been tested, and the testing has been documented.	X					Healthy Blue has an extensive disaster recovery plan. The plan covers the parties responsible for recovery, how to identify a disaster, the recovery process, damage assessment, and disaster recovery communications. Additionally, Healthy Blue works with its vendors and parent organization to conduct several recovery exercises each year to ensure its systems can be restored according to recovery time objectives.
I D. Compliance/Program Integrity						
1. The MCO has a Compliance Plan to guard against fraud and abuse.	X					The Compliance Plan outlines written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable federal and state standards and regulations. A PI Plan is in place with processes to safeguard against unnecessary

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						or inappropriate use of Medicaid services and against improper payments.
2. The Compliance Plan and/or policies and procedures address requirements, including:	X					
2.1 Standards of conduct;						The Compliance Overview and Our Values emphasizes the commitment to conducting business operations in compliance with state and federal guidelines. Staff are trained and attest to the standards of conduct at the time of hire and annually thereafter.
2.2 Identification of the Compliance Officer and Program Integrity Coordinator;						The Compliance Officer is identified on the Organizational Chart.
2.3 Inclusion of an organization chart identifying names and titles of all key staff;						
2.4 Information about the Compliance Committee;						
2.5 Compliance training and education;						Continuing compliance education and training of employees is an essential element of Healthy Blue's Compliance Plan. All new employees are required to complete training on Our Values within 30 days of their date of hire. Each year thereafter, every employee must take the company's Compliance Challenge refresher course, which covers ethics, the code of conduct, HIPAA privacy and security, and fraud, waste, and abuse (including The False Claims Act and other relevant legislation).

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.6 Lines of communication;						Open communication is encouraged. An employee may contact the Compliance Officer with questions or concerns. In the event a person wishes to remain anonymous, they may use Healthy Blue's confidential Fraud Hotline that is available 24 hours a day, 7 days a week to report suspected cases of fraud, abuse or other noncompliance.
2.7 Enforcement and accessibility;						
2.8 Internal monitoring and auditing;						Monitoring activities include ongoing assessment of program risk areas, establishing metrics for self-reporting, and reviewing corrective actions taken to address identified risks. Compliance reviews are based on regulatory guidance.
2.9 Response to offenses and corrective action;						Healthy Blue monitors activities outlined in the Compliance Plan. This includes establishing an auditing and monitoring plan, continuously reviewing the plan's results to identify and address organizational areas of risk, assisting in the development of corrective action plans, and monitoring the implementation and successful completion of any corrective action plan.
2.10 Data mining, analysis, and reporting;						
2.11 Exclusion status monitoring.						Healthy Blue will not knowingly hire, contract with, or retain any person or entity that is currently debarred, suspended, excluded, or

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						otherwise ineligible to participate in federal and/or state health care programs. Pre-employment background checks are conducted for all potential employees, providers, and contractors. Federal and state exclusion databases are reviewed to ensure the individual has not been deemed ineligible to participate in the program, and all employees and providers are reviewed against federal and state exclusion databases on a monthly basis thereafter.
3. The MCO has an established committee responsible for oversight of the Compliance Program.	X					
4. The MCO's policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse.	X					
5. The MCO's policies and procedures define how investigations of all reported incidents are conducted.	X					
6. The MCO has processes in place for provider payment suspensions and recoupments of overpayments.	X					
7. The MCO implements and maintains a statewide Pharmacy Lock-In Program (SPLIP).	X					
I E. Confidentiality *42 CFR § 438.224*						
1. The MCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy.	X					The Compliance Overview and Our Values outline Healthy Blue's procedures for HIPAA, privacy and security, and the reporting steps for instances of violation and prevention. Policy MCD-09 emphasizes that beneficiaries enrolled in

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						managed care program are protected by corporate policies and procedures and assured of Healthy Blue's commitment to compliance with all federal and state privacy and confidentiality laws, rules and regulations.

II. PROVIDER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II. PROVIDER SERVICES						
II A. Credentialing and Recredentialing *42 CFR § 438.214, 42 CFR § 457.1233(a)*						
1. The MCO formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in a manner consistent with contractual requirements.	X					Processes and requirements for provider credentialing and recredentialing are documented in: •The Healthy Blue Credentialing Program Plan •Policy MCD-04, Initial Credentialing •Policy MCD-05, Recredentialing •Policy MCD-06, Health Care Delivery Organizations - Credentialing/Recredentialing

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The Credentialing Committee Charter and Policy MCD-06 include statements that Healthy Blue follows NCQA credentialing and recredentialing standards, but a similar statement was not noted in Policy MCD-04 and Policy MCD-05. *Recommendation: Revise Policy MCD-04 and Policy MCD-05 to reflect that NCQA credentialing and recredentialing standards are followed.*
2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the MCO.	X					The BlueChoice HealthPlan Credentialing Committee is responsible for all credentialing and recredentialing activities for all providers except behavioral health providers. The Companion Benefit Alternatives (CBA) Credentialing Committee is responsible for all credentialing and recredentialing activities for behavioral health providers. The BlueChoice HealthPlan Credentialing Committee's membership includes external physicians representing specialties of Dentistry, Pediatrics, Pulmonology, Obstetrics and Gynecology, General Surgery, and Internal Medicine. In addition, there are two Nurse Practitioners and a Chiropractor included in the membership.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Onsite discussion and submitted Credentialing Committee minutes confirmed meetings are held monthly. However, the Credentialing Program Plan: •Page 1, states, "The Credentialing Committee is authorized to meet as necessary, but no less than quarterly…" •Page 2 states, "Focused Review committee meetings occur bi-monthly beginning in February of each year." The Provider Credentialing/Recredentialing Charter does not define the quorum for Credentialing Committee meetings. Onsite discussion confirmed the quorum is 3 external providers. Review of committee minutes confirmed the presence of a quorum at each meeting. *Recommendation: Revise the Credentialing Program Plan, pages 1 and 2, to clearly indicate that Credentialing Committee meetings are held monthly. Update the Credentialing/ Recredentialing Charter to include the quorum for Credentialing Committee meetings.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The credentialing process includes all elements required by the contract and by the MCO's internal policies.	X					
3.1 Verification of information on the applicant, including:						Fourteen initial credentialing files were reviewed for providers. Identified issues are addressed in standards 3.1.1 through 3.2 below.
3.1.1 Current valid license to practice in each state where the practitioner will treat members;	X					
3.1.2 Valid DEA certificate and/or CDS certificate;	X					
3.1.3 Professional education and training, or board certification if claimed by the applicant;	X					
3.1.4 Work history;	X					
3.1.5 Malpractice claims history;	X					
3.1.6 Formal application with attestation statement delineating any physical or mental health problem affecting ability to provide health care, any history of chemical dependency/ substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.7 Query of the National Practitioner Data Bank (NPDB);	X					
3.1.8 No debarred, suspended, or excluded from Federal procurement activities: Query of System for Award Management (SAM);	X					
3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline);	X					
3.1.10 Query of the State Excluded Provider's Report and the SC Providers Terminated for Cause List;	X					
3.1.11 Query for Medicare and/or Medicaid sanctions (5 years); OIG List of Excluded Individuals and Entities (LEIE);	X					
3.1.12 Query of Social Security Administration's Death Master File (SSDMF);	X					
3.1.13 Query of the National Plan and Provider Enumeration System (NPPES);	X					
3.1.14 In good standing at the hospital designated by the provider as the primary admitting facility;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.15 Clinical Laboratory Improvement Amendment (CLIA) Certificate (or certificate of waiver) for providers billing laboratory procedures;		X				Three of the 14 initial credentialing files did not include CLIA certificates for all practice locations. Onsite discussion confirmed credentialing staff verify the CLIA only for the primary practice location, and CLIA certificates for other locations are maintained in the Claims area. *Quality Improvement Plan: Revise credentialing processes to include evidence of CLIA certificates for all applicable practice locations in the credentialing files.*
3.2 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					
4. The recredentialing process includes all elements required by the contract and by the MCO's internal policies.	X					
4.1 Recredentialing conducted at least every 36 months;	X					
4.2 Verification of information on the applicant, including:						18 provider recredentialing files were reviewed. Identified issues are addressed in standards 4.2.1 through 4.3 below.
4.2.1 Current valid license to practice in each state where the practitioner will treat members;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.2 Valid DEA certificate and/or CDS certificate;	X					
4.2.3 Board certification if claimed by the applicant;	X					
4.2.4 Malpractice claims since the previous credentialing event;	X					
4.2.5 Practitioner attestation statement;	X					
4.2.6 Requery the National Practitioner Data Bank (NPDB);	X					
4.2.7 Requery of System for Award Management (SAM);	X					
4.2.8 Requery for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline);	X					
4.2.9 Requery of the State Excluded Provider's Report and the SC Providers Terminated for Cause List;	X					
4.2.10 Requery for Medicare and/or Medicaid sanctions since the previous credentialing event; OIG List of Excluded Individuals and Entities (LEIE);	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.11 Query of the Social Security Administration's Death Master File (SSDMF);	X					
4.2.12 Query of the National Plan and Provider Enumeration System (NPPES);	X					
4.2.13 In good standing at the hospitals designated by the provider as the primary admitting facility;	X					
4.2.14 Clinical Laboratory Improvement Amendment (CLIA) Certificate for providers billing laboratory procedures;		X				Three of the 18 recredentialing files did not include CLIA certificates for all practice locations. Onsite discussion confirmed credentialing staff verify the CLIA only for the primary practice location, and CLIA certificates for other locations are maintained in the Claims area. *Quality Improvement Plan: Revise recredentialing processes to include evidence of CLIA certificates for all applicable practice locations in the recredentialing files.*
4.3 Review of practitioner profiling activities.	X					
5. The MCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the MCO for serious quality of care or service issues.	X					Policy MCD-07, Professional Practitioner – Restriction, Suspension or Termination, confirms that the Credentialing Committee or Medical Director may restrict, suspend or terminate participating providers based on

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						issues of quality of care or service, including breaches of contract. For identified or reported serious quality deficiencies, the Medical Director determines if there a need for further investigation and may present the case to the Credentialing Committee for further guidance. Once investigated, the case is presented to the Physician Disciplinary Panel. If the panel recommends restriction, suspension or termination, the provider is notified via certified letter that includes specific information about the quality issue, the reason it is being investigated, a summary of appeal rights, and the timeframe for appeal. All suspensions and terminations due to quality issues are reported to the NPDB, the state licensing board, and SCDHHS.
6. Organizational providers with which the MCO contracts are accredited and/or licensed by appropriate authorities.	X					A total of five files were reviewed for organizational provider credentialing and recredentialing. No issues were identified.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
7. Monthly provider monitoring is conducted by the MCO to ensure providers are not prohibited from receiving Federal funds.	X					A policy titled Excluded Individuals and Entities – Prohibition on Hiring or Contracting states the MCO will not contract with any individual or entity that it discovers has been excluded from participation in federal or state health care programs or other federal or state procurement programs. Screening is performed prior to engagement/contracting of services and periodically thereafter. Provider Credentialing staff screen prospective providers prior to completing the credentialing process and contract execution and at re-credentialing. Provider Relations, National Customer Care and/or Health Care Management screens prospective providers before executing a single case agreement. Anthem Provider Data Operations staff screen non-contracted providers prior to configuring them to receive payment from the company. All active providers are monitored monthly against all applicable Exclusion Lists. The exclusion lists include the DHHS OIG LEIE, GSA SAM, and similar lists prepared by state authorities.
II B. Adequacy of the Provider Network *42 CFR § 438.206, 42 CFR § 438.207, 42 CFR § 10(h), 42 CFR § 457.1230(a), 42 CFR § 457.1230(b)*						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.The MCO maintains a network of providers that is sufficient to meet the health care needs of members and is consistent with contract requirements.						
1.1 Members have a primary care physician located within a 30-mile radius of their residence.	X					Policy MCD-11, Medicaid Access/Availability Standard, appropriately defines the access standard for primary care providers. The policy states access and availability standards are measured at least annually through various methodologies, including Geo Access reports, CAHPS surveys, analysis of member complaints, and "secret shopper" surveys. The analyses of practitioner accessibility are conducted by QI and Provider Services staff, the SQIC, and other committees as applicable. Action plans are developed as needed to address problem areas. The Healthy Blue Network Analysis, SC Medicaid Members documents dated February 19, 2021, reflect use of the correct parameter for measuring PCP access. The report reflects there are 1,886 PCPs at 1,044 locations throughout the state and that 100% of members have access to PCPs within the required time/distance standards. Members in all counties have access to at least 2 PCPs within the 30 miles/45-minute access standard.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.2 Members have access to specialty consultation from a network provider located within reasonable traveling distance of their homes. If a network specialist is not available, the member may utilize an out-of-network specialist with no benefit penalty.	X					Policy MCD-11 appropriately documents the standard for specialist and hospital access. The Healthy Blue Network Analysis, SC Medicaid Members documents (dated February 18, 2021) indicate for most counties, 100% of members have the required access to required specialists. Counties with less than 100% are generally rural counties and efforts continue to recruit additional providers for these counties.
1.3 The sufficiency of the provider network in meeting membership demand is formally assessed at least bi-annually.	X					
1.4 Providers are available who can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs.	X					Healthy Blue's processes to ensure the availability providers who can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs are documented in a policy titled, "Provider Network, Cultural Responsiveness." Processes include: •Offering a comprehensive provider awareness and training program and providing regular education to provider offices. One-on-one provider training is provided when requested and when a need is identified. •Informing providers of the availability of interpreter services at no cost to the member.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•Assessing the adequacy of the network based on member population and other variables such as member language preferences. •Conducting an annual assessment to analyze the ability of the network to meet members' language needs and to provide culturally competent care. The BlueChoice HealthPlan of South Carolina Medicaid 2021 Cultural Needs Assessment (Measurement Year 2020) documents an analysis conducted in December 2020 of the network's ability to meet members' cultural, racial, ethnic, and linguistic needs. The report identifies ongoing activities, including: •Continued attempts to recruit minority and Spanish-speaking physicians. •Expanding health and disease management program materials to promote free program services and expanding availability of alternate language and diversity-based member media and interventions. •Continuing the "Cultural Competency Issues for Case Managers' training program and offering cultural awareness education for professional staff. •Obtaining accurate call numbers from the language interpretation vendor and monitoring face-to-face interpreter service requests.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•Updating linguistics data as available from the US Census Bureau.
1.5 The MCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand.	X					
2. The MCO maintains a provider directory that includes all requirements outlined in the contract.	X					The Provider Directories policy lists elements that must be included in the Provider Directory but does not include office hours or age groups, as required by the *SCDHHS Contract, Section 3.13.5.1.1.* Review of the Healthy Blue Provider Directory (print version and online) confirmed all required elements are included. The Provider Directories policy states the online provider data is updated daily and is available 24 hours a day, 7 days a week via the provider search tool on the website. Paper directories must be updated at least monthly and electronic directories must be updated no later than 30 calendar days after the MCO receives updated provider information. *Recommendation: Revise the Provider Directories policy to include office hours and age groups as required elements of the Provider Directory.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.Practitioner Accessibility *42 CFR § 438.206(c)(1), 42 CFR § 457.1230(a), 42 CFR § 457.1230(b)*						
3.1 The MCO formulates and ensures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.	X					Appointment access standards for PCPs and specialists are defined in Policy MCD-11, Medicaid Access/Availability Standard. The policy does not include the requirement that for PCPs, walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling procedures, as required by the *SCDHHS Contract, Section 6.2.2.3.5*. Healthy Blue monitors appointment access in various ways, including data from CAHPS surveys, site visits, member complaints/grievances, and "secret shopper" surveys. A draft of the 2020 Healthy Blue Practitioner Access Analysis was submitted during the onsite and revealed all goals were met for after-hours access PCP appointment access. Goals were not met initially for urgent care appointments for High Volume specialists, with no improvement after re-survey. The analysis included key drivers of results, identified barriers, opportunities for Improvement, and interventions.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.2 The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results.			X			The Healthy Blue Provider File contained a population of 2,430 PCPs. From that, a random sample of 176 PCPs was selected for the provider access study. PCPs were chosen based on the following criteria: MD, DO, NP, ANP, CFNP, and FNP. The specialties selected were Family Practice, General Practice, Internal Medicine, Nurse Practitioner, and Pediatrics. Only Providers located in SC and documented as accepting new patients were selected for the sample. Attempts were made to contact these providers to ask a series of questions regarding the access that members have with the contracted providers. In reference to the results of the Telephone Provider Access Study, conducted by CCME, calls were successfully 59% of the time. When compared to last year's results of 77%, the decrease in successful answer rate was statistically significant (p = .0002). For those not answered successfully (n=67 calls), 33 (49.3%) were unsuccessful because the provider was not at that office or phone number listed. *Quality Improvement Plan: Examine current methods to update provider information; ensure all provider files are up to date; offer providers several methods to update contact*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						information and primary location. Check the unsuccessful calls file from CCME.
II C. Provider Education *42 CFR § 438.414, 42 CFR § 457.1260*						
1. The MCO formulates and acts within policies and procedures related to initial education of providers.	X					Processes and requirements for provider education are found in Policy MCD-01, Education of Contracting Providers. The policy also includes topics covered in provider education. Provider education is conducted at contracting and periodically as needed. Provider Network Management staff are responsible for the provider education activities. Education is provided through various avenues such as on-site orientation, virtual provider training, providing educational materials and references, provider updates on the website and in special mailings, annual workshops, and routine on-site/virtual contacts. Provider training sessions are held in at least four regional locations throughout the state at least once a year, conducted virtually when on-site provider trainings are not an option. Individual on-site or virtual visits/educational workshops are conducted as needed.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The new provider training PowerPoint document is comprehensive, includes contact information, and is a great resource for providers. Healthy Blue staff reported that a copy of this presentation is given to providers and is available on the website.
2. Initial provider education includes:						
2.1 MCO structure and health care programs;	X					
2.2 Billing and reimbursement practices;	X					Information about claims, claims submission, and provider disputes is included in the orientation presentation and in the Provider Manual. When comparing copayment information in the Member Handbook and Provider Manual, CCME noted, the Member Handbook, page 11, states members in Waiver services do not have copayments. However, the Provider Manual does not include this information. *Recommendation: Update the Provider Manual to include information that members in Waiver services do not have copayments.*
2.3 Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by SCDHHS;	X					Information about member benefits, including covered services, excluded services, and services provided under fee-for-service is

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						included in the orientation presentation and in the Provider Manual.
2.4 Procedure for referral to a specialist;	X					
2.5 Accessibility standards, including 24/7 access;	X					
2.6 Recommended standards of care;	X					The Provider Manual includes an overview of clinical practice and preventive health guidelines and directs the reader to the Healthy Blue website for more information.
2.7 Medical record handling, availability, retention and confidentiality;	X					Policy SC_QMXX_105, Medical Record Compliance Audit For Documentation Standards, states medical record review standards and goals are communicated to practitioners through the Provider Manual. However, the medical record documentation standards could not be located in the Provider Manual, and the Provider Manual does not direct the reader to the standards elsewhere, such as on the website. Additional documents were reviewed to determine how providers are informed of the medical record documentation standards: •The Sample Provider Contract and does not specify the medical record documentation standards.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•A documentation titled "Reimbursement Policy" found on the website listed required elements for documentation of an episode of care, but the document included a statement that, "Healthy Blue requires that documentation for all episodes of care must meet the following criteria unless provider, state, federal or CMS contracts and/or requirements indicate otherwise." This was discussed during the onsite. Healthy Blue staff confirmed this information is not provided during provider education sessions and could not specify how providers are informed of the specific medical record documentation standards to which they are required to comply. *Recommendation: Revise the Provider Manual to include the specific medical record documentation standards to which providers must comply, as stated in Policy SC_QMXX_105. It is recommended that the standards be posted on the website as well.*
2.8 Provider and member grievance and appeal procedures;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.9 Pharmacy policies and procedures necessary for making informed prescription choices;	X					
2.10 Reassignment of a member to another PCP;	X					
2.11 Medical record documentation requirements.	X					
3. The MCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies and procedures.	X					
II D. Primary and Secondary Preventive Health Guidelines *42 CFR § 438.236, 42 CFR § 457.1233(a)*						
1. The MCO develops preventive health guidelines for the care of its members that are consistent with national standards and covered benefits and that are periodically reviewed and/or updated.	X					Policy SC_PCXX_006, Preventive Health Guidelines (PHGs) - Review, Adoption, Distribution and Performance Monitoring, states Amerigroup approves for adoption the preventive health guidelines (PHGs), which incorporate current, evidence-based guidelines from nationally recognized sources. The corporate-level Clinical Practice Guidelines/ Preventive Health Guidelines (CPG/PHG) Workgroup includes Medical Directors and representation from departments across the organization and reviews

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						recommended changes annually or whenever pertinent or new evidence is available. The guidelines are then sent to the CQIC for approval and adoption prior to publication on the website.
2. The MCO communicates the preventive health guidelines and the expectation that they will be followed for MCO members to providers.	X					PHGs are posted on the website, and information about the availability of the PHGs is included in the Provider Manual. Newly contracted providers are informed of the PHGs through their Welcome Materials. Provider compliance with PHGs is monitored through Medical Record Compliance Audits and HEDIS performance gap-in-care data. Information about PHGs on the website includes guidelines for well-baby and well-child visits, wellness guidelines for adult women, pregnant women, adult men, and the suggested vaccine schedule for all ages.
3. The preventive health guidelines include, at a minimum, the following if relevant to member demographics:						
3.1 Well child care at specified intervals, including EPSDTs at State-mandated intervals;	X					
3.2 Recommended childhood immunizations;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.3 Pregnancy care;	X					
3.4 Adult screening recommendations at specified intervals;	X					
3.5 Elderly screening recommendations at specified intervals;	X					
3.6 Recommendations specific to member high-risk groups;	X					
3.7 Behavioral Health Services.	X					
II E. Clinical Practice Guidelines for Disease, Chronic Illness Management, and Behavioral Health Services *42 CFR § 438.236, 42 CFR § 457.1233(a)*						
1. The MCO develops clinical practice guidelines for disease, chronic illness management, and behavioral health services of its members that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated and are developed in conjunction with pertinent network specialists.	X					Policy SC_QMXX_048, Clinical Practice Guidelines - Review, Adoption and Distribution states Amerigroup reviews and approves for adoption medical and behavioral health CPGs that are relevant to the membership population; aid members and providers in decision-making about acute and chronic medical and behavioral health care; incorporate current, evidence-based guidelines from recognized sources; and meet NCQA, regulatory and/or contractual requirements.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Review of the 2021 Clinical Practice Guidelines document on the website indicates the guidelines were most recently adopted in January 2021 and include various medical and behavioral health conditions. CCME noted that page 2 of Policy SC_QMXX_048 states, "The Clinical Practice Guidelines are updated at least annually or when changes are made to national guidelines." However, page 3 states, "The Guidelines Team reviews existing Clinical Practice Guidelines at least every two years or when new evidence is available." This was discussed during the onsite and it was determined that the reference on page 3 to reviewing the guidelines every 2 years is an error. *Recommendation: Revise page 3 of Policy SC_QMXX_048 to indicate the correct frequency for review of CPGs.*
2. The MCO communicates the clinical practice guidelines for disease, chronic illness management, and behavioral health services and the expectation that they will be followed for MCO members to providers.	X					Once approved by the CQIC, CPGs are disseminated to providers and are available to both practitioners and members via the Healthy Blue website. Information about the availability of the guidelines is included in the Provider Manual and new providers are informed of the CPGs through welcome

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						materials. Written copies of the guidelines are provided upon request. Provider compliance to the CPGs is assessed through medical record audits and monitoring utilization and HEDIS performance gap-in-care data.
II F. Continuity of Care *42 CFR § 438.208, 42 CFR § 457.1230(c)*						
1. The MCO monitors continuity and coordination of care between the PCPs and other providers.	X					The QI Program Description and various policies address care coordination. The QM Program Description states, "The Plan assists members with multiple or complex conditions to obtain access to care and services and coordinates this care." Opportunities are identified to improve care coordination by analyzing data on care transitions between practitioners and across settings. Actions are taken on opportunities identified and the effectiveness of actions measured. Care coordination between providers is primarily assessed through medical record reviews.
II G. Practitioner Medical Records						
1. The MCO formulates policies and procedures outlining standards for acceptable documentation in the member medical records maintained by primary care physicians.	X					Policy SC_QMXX_105, Medical Record Compliance Audit For Documentation Standards, describes processes and requirements for assessing provider medical record documentation. Amerigroup's Clinical

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Quality Department conducts annual medical record reviews to assess PCP compliance with medical record documentation standards. Providers selected for audit are an equal representation of all providers in the network, regardless of member panel size. The policy describes the annual medical record review process, including scoring expectations, and processes followed when providers do not meet the scoring threshold.
2. Standards for acceptable documentation in member medical records are consistent with contract requirements.	X					
3. Medical Record Audit						
3.1 The MCO monitors compliance with medical record documentation standards through periodic medical record audit and addresses any deficiencies with the providers.	X					Healthy Blue provided the results of the 2020 Medical Record Compliance Audit. A total of 142 medical records across 30 providers were audited. All records achieved the threshold score of 90% with most scoring 100%.
4. Accessibility to member medical records by the MCO for the purposes of quality improvement, utilization management, and/or other studies is contractually assured for a period of 5 years following expiration of the contract.	X					

III. MEMBER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
III. MEMBER SERVICES						
III A. Member Rights and Responsibilities *42 CFR § 438.100, 42 CFR § 457.1220*						
1. The MCO formulates and implements policies guaranteeing each member's rights and responsibilities and processes for informing members of their rights and responsibilities.	X					Policy SC_ QMXX_104, Member Rights and Responsibilities, describes Healthy Blue's process for ensuring and informing members of their rights and responsibilities according to *SCDHHS Contract, Section 3.16*. Members are primarily informed of their rights and responsibilities via the Member Handbook and the website.
2. Member rights include, but are not limited to, the right:	X					Member rights are correctly listed in the Member Handbook, Provider Manual, and on the website. As a follow up from the 2020 EQR, Healthy Blue has listed member rights and responsibilities in a prominent location on the website with an easily identifiable tab and a dedicated page.
2.1 To be treated with respect and with due consideration for dignity and privacy;						
2.2 To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.3 To participate in decision-making regarding their health care, including the right to refuse treatment;						
2.4 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, in accordance with Federal regulations;						
2.5 To be able to request and receive a copy of the member's medical records and request that they be amended or corrected as specified in Federal regulation (*45 CFR Part 164*);						
2.6 To freely exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCO and its providers or the Department treat the Medicaid MCO Member.						
III B. Member MCO Program Education *42 CFR § 438.56, 42 CFR § 457.1212, 42 CFR § 438.3(j)*						
1. Members are informed in writing within 14 calendar days from the MCO's receipt of enrollment data of all benefits and MCO information including:	X					The Member Handbook and the Evidence of Coverage Change Control Log are easily accessible on the website. CCME identified the Evidence of Coverage Change Control log does not include a date that indicates when changes were made.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Policy SC_COXX_126, Annual Notification to Members, state members are provided a welcome packet within 14 days of Healthy Blue receiving the member's enrollment data from SCDHHS. The welcome packet includes the member ID card along with directions to access or request a Provider Directory, member rights and responsibilities, and the Notice of Privacy Practices. Onsite discussion confirmed the welcome kit includes a paper copy of the Member Handbook. Additionally, new members receive automated welcome calls, specific to South Carolina, that provide healthcare benefit information. Members are informed that the "New Member Guide" and "Quick start Guide" are resources available on the website. CCME identified inconsistent documentation in the New Member Materials Distribution policy, which incorrectly states the timeframe for mailing new member packets is, "No later than the 15th day of the month in which the Member is enrolled." According to the *SCDHHS Contract, Section 3.14.3*, Healthy Blue is required to provide education no later than 14 calendar days after receiving enrollment data.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Edit the Evidence of Coverage Change Control Log to include a date indicating when changes were made. Correct the New Member Materials Distribution policy to reflect that New Member Packets are mailed within 14 days of Healthy Blue receiving the member's enrollment data from SCDHHS.
1.1 Benefits and services included and excluded in coverage;						The Member Handbook and Provider Manual include a benefits table that describes covered services with applicable limits and exclusions. Additionally, benefit information is noted on the website and members can contact the Customer Care Center to obtain this information. Policy SC_COXX_126, Annual Notification to Members, describes Healthy Blues' approach to notifying members of their covered services and benefits.
1.1.1 Direct access for female members to a women's health specialist in addition to a PCP;						
1.1.2 Access to 2nd opinions at no cost, including use of an out-of-network provider if necessary.						
1.2 How members may obtain benefits, including family planning services from out-of-network providers;						
1.3 Any applicable deductibles, copayments, limits of coverage, and maximum allowable benefits;						A table listing copayments and limits of coverage is included in the Member Handbook and Provider Manual. The "Zero Dollar Copay List" for specific

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						medications is posted to the member website. Healthy Blue informs members that copayments do not apply to specific identified populations and for certain services, such as well-child/well-baby visits or vaccines for children under 19 years old, members receiving hospice services, and members who are pregnant. CCME identified the following copayment errors in the Member Handbook: •Page 16 indicates the copayment for inpatient hospital services is $2.00 instead of $25.00. •Page 17 lists the copayment for outpatient hospital services for members 19 years of age and older who receive non-emergency services in the emergency room as $3.30 instead of $3.40. *Recommendation: Update the Member Handbook to indicate the correct copayment amount for inpatient hospital services and outpatient hospital services (non-emergency) according to the SC Medicaid Copayment Schedule.*
1.4 Any requirements for prior approval of medical or behavioral health care and services;						Services that require prior authorization are clearly listed throughout the Member Handbook. Prior approval is not required for family planning services, emergency visits, or behavioral health services.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.5 Procedures for and restrictions on obtaining out-of-network medical care;						
1.6 Procedures for and restrictions on 24-hour access to care, including elective, urgent, and emergency medical services, including post-stabilization services;						Members are informed that in addition to their PCP, the Nurse Advice Line is available 24 hours a day, seven days a week. Members are instructed to call 911 or go to the nearest hospital if they are experiencing what they perceive to be an emergency. The Member Handbook and the website describe and define behavioral and physical health emergency services and provide clear and specific information instructing members on the appropriate level of care for routine, urgent, or emergent health care needs.
1.7 Policies and procedures for accessing specialty care;						
1.8 Policies and procedures for obtaining prescription medications and medical equipment, including applicable restrictions;						The Member Handbook includes information on obtaining prescription medications and durable medical equipment. Members are directed to the website to view the Preferred Drug List and to find participating pharmacies or contact Member Services to obtain this information.
1.9 Policies and procedures for notifying members affected by changes in benefits, services, and/or the provider network;						The Member Handbook describes Healthy Blue's process for notifying members affected by changes in benefits and services. Healthy Blue will provide written notice to members 30 days before the expected change of benefits and 15 days after receipt of a provider's termination from the network.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.10 Procedures for selecting and changing a primary care provider and for using the PCP as the initial contact for care;						Instructions for managing PCP selection and scheduling appointments are available in the Member Handbook and on the website. Members can call the Customer Care Center for assistance or log into their secured online account to change their PCP. Additionally, instructions on pages 1 and 26 of the Member Handbook advise members to "fill out the PCP Selection form at the end of this book and mail it to us." However, CCME did not identify a PCP Selection form in the Member Handbook. *Recommendation: Edit the Member Handbook to include a PCP Selection form or remove the reference to the form from the handbook.*
1.11 Procedures for disenrolling from the MCO;						
1.12 Procedures for filing grievances and appeals, including the right to request a Fair Hearing;						Detailed information and instructions for filing grievances, appeals, and State Fair Hearings are noted in the Member Handbook and easily located on the website.
1.13 Procedure for obtaining the names, qualifications, and titles of the professionals providing and/or responsible for their care and of alternate languages spoken by the provider's office;						The Member Handbook informs members to use the online Provider Directory or call the Customer Care Center to obtain information about providers. A searchable Provider Directory is available on the website and members can request a paper copy.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.14 Instructions on how to request interpretation and translation services at no cost to the member;						
1.15 Member's rights, responsibilities, and protections;						
1.16 Description of the Medicaid card and the MCO's Medicaid Managed Care Member ID card, why both are necessary, and how to use them;						The Member Handbook describes the importance of, and provides instruction for, using the South Carolina Healthy Connections and Healthy Blue ID cards. A sample picture of the Healthy Blue ID card is included.
1.17 A description of Member Services and the toll-free number, fax number, e-mail address and mailing address to contact Member Services;						The Member Handbook and website provide the Customer Care Center's hours of operation, toll-free number, fax number, and mailing address. Members can communicate with the health plan via email when logged into the secured member portal.
1.18 How to make, change, and cancel medical appointments and the importance of canceling and/or rescheduling appointments when necessary;						
1.19 Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;						The Member Handbook adequately defines and describes the requirements and recommended schedule for Early and Periodic Screening, Diagnosis and Treatment services. Additionally, detailed information on EPSDT services is posted on the website and includes a link to the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						American Academy of Pediatrics and Bright Futures Periodicity Schedule.
1.20 A description of Advance Directives, how to formulate an advance directive, and how to receive assistance with executing an advance directive;						
1.21 Information on how to report suspected fraud or abuse;						
1.22 Additional information as required by the contract and/or federal regulation;						
2. Members are notified at least once per year of their right to request a Member Handbook or Provider Directory.	X					Healthy Blue notifies members of their right to request a copy of the Provider Directory and Member Handbook annually as noted in Policy, SC_COXX_126, Annual Notification to Members. Healthy Blue sends the Annual Member Notice mailer to every head of household informing them that annual information is available for viewing on the website.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Onsite discussion confirmed Healthy Blue has discontinued annual member newsletters; however, Policy, SC_COXX_126, Annual Notification to Members, states, "Directions on how to request information is included in the Evidence of Coverage (EOC), on an annual basis in the Annual Newsletter, and upon direct request to the Customer Care Center (CCC)." *Recommendation: Remove the reference to the Annual Newsletter from Policy, SC_COXX_126, Annual Notification to Members.*
3. Members are informed in writing of changes in benefits and changes to the provider network.	X					Policy SC_COXX_126, Annual Notification to Members and Policy, SC_PNXX_303, Provider Termination and Member Notification, explains Healthy Blue notifies members in writing within 15 days after a receipt of a provider's termination from the network and at least 30 days before the effective date of a change in benefits.
4. Member program education materials are written in a clear and understandable manner and meet contractual requirements.	X					
5. The MCO maintains, and informs members how to access, a toll-free vehicle for 24-hour member access to coverage information from the MCO.	X					Healthy Blue addresses CCC staffing, personnel, hours of operation, access and response standards, and monitoring of calls in Policy SC_CSPC_002, Customer Service.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The CCC is located in Las Vegas and Texas and staffed Monday through Friday from 8 a.m. to 6 p.m. Outside of normal business hours, the Interactive Voice Response system instructs to call 911 or go to the nearest emergency room for life-threatening emergencies. Callers are given the option to leave a message to which a response is provided within one business day. Free interpreter and translation services are provided to members who have limited English proficiency, and hearing, speech, or sight communication barriers. Healthy Blue monitors the CCC to ensure compliance with performance and response standards, according to requirements in the *SCDHHS Contract, Section 3.18.14*. Discussion during the onsite confirmed performance goals were met for member and provider call services.
III C. Member Enrollment and Disenrollment *42 CFR § 438.56*						
1. The MCO enables each member to choose a PCP upon enrollment and provides assistance if needed.	X					
2. MCO-initiated member disenrollment requests are compliant with contractual requirements.	X					Healthy Blue must submit a detailed written request for member disenrollment to SCDHHS, according to processes described in Policy

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						SC_UMXX_125, Termination of Membership (Disenrollment) - Coordination of Care.
III D. Preventive Health and Chronic Disease Management Education						
1. The MCO informs members of available preventive health and disease management services and encourages members to utilize these services.	X					Members can access the website or Member Handbook for information on preventive health services, case management programs, and obtaining educational support for medical, behavioral health, and pharmaceutical services. Healthy Blue encourages members to utilize services by providing Healthy Rewards gift cards to retail stores when members complete wellness visits or preventive screenings.
2. The MCO tracks children eligible for recommended EPSDT services/immunizations and encourages members to utilize these benefits.	X					Healthy Blue ensures EPSDT services for members through the month of their 21st birthday as described in Policy SC_PCXX_009, Pediatric Preventive Services/Provision of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services. The policy describes processes and methods for notification, tracking, and follow-up of the EPSDT program.
3. The MCO provides education to members regarding health risk factors and wellness promotion.	X					
4. The MCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks the	X					The Maternal Child Services Obstetrical and NICU Case Management Program Description describes and outlines Healthy Blue's approach to providing maternity services and identifying eligible women

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
participation of pregnant members in recommended care.						and newborns. The Member Handbook instructs pregnant members about various education and support programs, such as the New Baby, New Life SM program, the My Advocate® telephonic program, Centering Pregnancy group prenatal care services, and NICU Case Management. Metrics for the Maternal Child Services program, such as staff performance, utilization, and quality measures, are monitored monthly and evaluated annually.
III E. Member Satisfaction Survey						
1. The MCO conducts a formal annual assessment of member satisfaction with MCO benefits and services. This assessment includes, but is not limited to:	X					Healthy Blue contracts with the Center for the Study of Services (CSS), a certified CAHPS survey vendor to conduct the Adult and Child surveys.
1.1 Statistically sound methodology, including probability sampling to ensure it is representative of the total membership;	X					The Child surveys did not meet the minimum sample size of 411 valid surveys, with a total of 192 completed out of 2,145, and the response rate was 8.96%, which is an 8.7% decrease from the 17.7% rate last year. Additionally, the Adult surveys used oversampling and had 185 valid surveys out of 1,755, with a response rate of 10.56%, an 8.7% decreased from last year's response rate of 19.3%. The Children with Chronic Conditions survey sample was below the target of 411, with 217

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						completed surveys out of 2,145, for a response rate of 10.12%. This is a decline from the 19% response rate in the previous review. Despite oversampling, the actual sample sizes were not adequate and did not meet the NCQA minimum sample size and number of valid surveys (at least 411), and the response rates were below the NCQA target of 40%. *Recommendation: Determine if CSS can offer interventions other than the current methods of oversampling, call script reminders, and website CAHPS banners, to improve the CAHPS response rates.*
1.2 The availability and accessibility of health care practitioners and services;	X					
1.3 The quality of health care received from MCO providers;	X					
1.4 The scope of benefits and services;	X					
1.5 Claim processing procedures;	X					
1.6 Adverse MCO claim decisions.	X					
2. The MCO analyzes data obtained from the member satisfaction survey to identify quality issues.	X					CSS summarizes and details all results from the adult and child surveys. The analysis and implementation of interventions to improve member satisfaction is conducted by the Service

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Quality Improvement Committees. The QI Evaluation displayed an analysis of data and action steps to achieve higher scores for member satisfaction.
3. The MCO implements significant measures to address quality issues identified through the member satisfaction survey.	X					The QIC minutes from October 2020 and the 2021 QI Work Plan indicated results were presented and action plans were initiated to address problematic survey measures.
4. The MCO reports the results of the member satisfaction survey to providers.	X					Survey results were offered to providers in the CAHPS Results Provider Notification Letter and the Provider Bulletin from February 2021.
5. The MCO reports results of the member satisfaction survey and the impact of measures taken to address identified quality issues to the Quality Improvement Committee.	X					The CAHPS Outcome report was presented to the QIC and to the SQIC in 2020.
III F. Grievances *42 CFR § 438. 228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260*						
1. The MCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to:	X					Policy SC_GAXX 015, Grievance and Appeals for Members, outlines procedures for the receipt, investigation, and resolution of member grievances.
1.1 The definition of a grievance and who may file a grievance;	X					Healthy Blue policies appropriately define grievance terminology and who may file a grievance.
1.2 Procedures for filing and handling a grievance;	X					Policies, the Member Handbook, and the plan website state that members or their representatives may file a grievance at any time and those grievances may be submitted orally or

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						in writing. Information is provided outlining the options for these processes. The Provider Manual states that a member may be assisted when requested. Arrangements may be made for individuals with disabilities and individuals with limited English proficiency are provided auxiliary aids and services or language assistance services, respectively, if needed to participate in the grievance process. The Member Handbook explains the grievance process, from the acknowledgement to the resolution.
1.3 Timeliness guidelines for resolution of a grievance;	X					
1.4 Review of grievances related to clinical issues or denial of expedited appeal resolution by a Medical Director or a physician designee;	X					
1.5 Maintenance and retention of a grievance log and grievance records for the period specified in the contract.	X					Healthy Blue maintains and submits a quarterly grievance log to SCDHHS as required. A copy of the grievance log is retained for a minimum of 10 years. Quarterly grievance logs were reviewed fulfilling these criteria for this standard.
2. The MCO applies grievance policies and procedures as formulated.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					
4. Grievances are managed in accordance with the MCO confidentiality policies and procedures.	X					

IV. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IV. QUALITY IMPROVEMENT						
IV A. The Quality Improvement (QI) Program *42 CFR §438.330 (a)(b) and 42 CFR §457.1240(b)*						
1. The MCO formulates and implements a formal quality improvement program with clearly defined goals, structure, scope and methodology directed at improving the quality of health care delivered to members.	X					The 2021 Quality Management Program Description describes the program's structure, accountabilities, scope, goals, and available resources. The QI Program Description is reviewed and updated at least annually and proved by the Clinical Quality Improvement Committee (CQIC) and the Service Quality Improvement Committee (SQIC).

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems.	X					Over-utilization and under-utilization of services are monitored using reports made available by the Plan Performance Management Analysts/Plan Finance Analysts. The results of the reviews are reported to the CQIC, SQIC, and are used to help implement strategies to achieve utilization targets consistent with clinical and quality indicators and identify fraud and abuse.
3. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframe for implementation and completion, and the person(s) responsible for the project(s).	X					Healthy Blue's QI Work Plan identifies activities related to program priorities aimed at addressing and improving the quality and safety of clinical care and services. The 2020 and 2021 Work Plans included the planned objective/activity, date for completion, responsible parties, and oversight committees. During the previous EQR, CCME recommended Healthy Blue include details and state requirements for each activity and to correct the dates for completion. Healthy Blue incorporated these recommendations into the work plans.
IV B. Quality Improvement Committee						
1. The MCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					The CQIC is the local committee responsible for the oversight of the QI Program. The committee charter outlines the committee's responsibilities, meeting frequency and quorum requirements.
2. The composition of the QI Committee reflects the membership required by the contract.	X					Membership of the CQIC is composed of internal and external health plan staff and network providers. . Current membership includes seven network providers specializing in Family Medicine, Pediatrics, OB/GYN,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Emergency Medicine, and Psychiatry. A quorum is met with the attendance of three network providers.
3. The QI Committee meets at regular quarterly intervals.	X					Per Appendix A, Medicaid Committee Structure 2021 of the QI Program Description, the meeting frequency for the CQIC as a minimum of four times per year. Minutes received validated the CQIC met four times in 2020.
4. Minutes are maintained that document proceedings of the QI Committee.	X					Minutes are recorded for each committee meeting and approved by the originating committee.
IV C. Performance Measures *42 CFR §438.330 (c) and §457.1240 (b)*						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures".	X					Healthy Blue produces HEDIS rates using software from two NCQA-certified measure vendors, Inovalon, Inc. and Cotiviti, Inc. The comparison from the previous to the current year revealed a strong increase in the Initiation of AOD Treatment for Opioid Abuse/Dependence for the total rate and 7- and 30-day follow up After Emergency Department Visit for Alcohol and Other Drug Dependence total rates. There were no measures with a substantial decline of greater than 10%. Details of the validation of the performance measures can be found in the *CCME EQR Validation Worksheets, Attachment 3.*
IV D. Quality Improvement Projects *42 CFR §438.330 (d) and §457.1240 (b)*						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population.	X					For this review, two PIPs were submitted and validated. Topics for PIPs include Access and Availability to Care and Comprehensive Diabetes Care.
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects".	X					All the PIPs scored in the "High Confidence in Reported Results" range. There are no corrective actions or recommendations. The Access to Care PIP is now closed and a new PIP will be established to replace it. Details of the validation of the PIPs are found in the *CCME EQR Validation Worksheets, Attachment 3.*
IV E. Provider Participation in Quality Improvement Activities						
1. The MCO requires its providers to actively participate in QI activities.	X					
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					Provider specific performance data is provided through the Gaps in Care Report sent to network providers annually. This report provides a snapshot of members with care gaps. Other performance data is provided in the HEDIS Measures Trending Report and the ER Diversion Report. Healthy Blue's provider manual directs providers to the website for additional information on the QI Program. The reports and information on the website related to Healthy Blue's performance was from 2018.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Update the Quality Improvement Program documents on the Healthy Blue website with current performance data results.
IV F. Annual Evaluation of the Quality Improvement Program *42 CFR §438.330 (e)(2) and §457.1240 (b)*						
1. A written summary and assessment of the effectiveness of the QI program for the year is prepared annually.	X					Annually, Healthy Blue evaluates the overall effectiveness of the QI Program and reports this evaluation to the Board of Directors, the CQIC and SQIC for recommendations and approval.
2. The annual report of the QI program is submitted to the QI Committee and to the MCO Board of Directors.	X					

V. UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V. Utilization Management						
V A. The Utilization Management (UM) Program						
1. The MCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to:	X					Healthy Blue's Utilization Management (UM) Program is incorporated within Amerigroup's Health Care Management (HCM) Division. The UM Program Description describes and defines collaboration between the UM Program with other HCM areas such as Care Management, Behavioral Health, Pharmacy Management, and Clinical Quality Management. It outlines the structure and defines the goals, scope, and staff roles for physical and behavioral health utilization management. The Pharmacy Program Description indicates the pharmacy program is managed by IngenioRx, a subsidiary of Anthem, Inc. The UM Program Description was last reviewed and approved by the CQIC on April 21, 2021.
1.1 structure of the program and methodology used to evaluate the medical necessity;	X					
1.2 lines of responsibility and accountability;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.3 guidelines / standards to be used in making utilization management decisions;	X					
1.4 timeliness of UM decisions, initial notification, and written (or electronic) verification;	X					Requirements for service authorization timeframes are correctly documented in Policy SC_UMXX_117, Decision and Notification Timeframes and the UM Program Description. Additionally, requirements are documented in the Member Handbook, Provider Manual, and on the website.
1.5 consideration of new technology;	X					Consideration of new technology or new uses of existing technologies is addressed in UM Program Description.
1.6 the absence of direct financial incentives or established quotas to provider or UM staff for denials of coverage or services;	X					The UM Program Description and Policy SC_UMXX_065, Separation of Financial and Medical Necessity Decision-Making state Healthy Blue does not provide incentives to reward restriction of medical care to members.
1.7 the mechanism to provide for a preferred provider program.	X					
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					
3. The UM program design is periodically reevaluated, including practitioner input on medical necessity determination guidelines and grievances and/or appeals related to medical necessity and coverage decisions.	X					The UM Program is reviewed, evaluated and updated annually, and results and recommendations are presented to the Medical Policy and Technology Assessment Committee (MPTAC) and the CQIC for review and approval.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V B. Medical Necessity Determinations *42 CFR § 438.210(a-e),42 CFR § 440.230, 42 CFR § 438.114, 42 CFR § 457.1230 (d), 42 CFR § 457. 1228*						
1. Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations.	X					UM standards and criteria are documented in Policy SC_UMXX_118, Utilization Management Decision and Screening Criteria, and Policy and Procedure Clinical Criteria for Utilization Management. Healthy Blue uses several review criteria, including MCG™ Guidelines, medical policies and clinical UM guidelines, and AIM Specialty Health guidelines for physical health, behavioral health, and durable medical equipment. Additionally, criteria from the American Society of Addiction Medicine (ASAM) are utilized for behavioral health and substance abuse services.
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					UM approval files reflect clinical and physician reviewers use approved criteria and relevant medical information as defined in the UM Program Description and Policy SC_UMXX_118, Utilization Management Decision and Screening Criteria.
3. Coverage of hysterectomies, sterilizations and abortions is consistent with state and federal regulations.	X					The processes for covering hysterectomies, sterilizations, and abortions are described in Policy SC_UMXX_129, Abortions, Sterilizations, Hysterectomies. The criteria for utilization are communicated in the Member Handbook and the Provider Manual. All applicable forms are available on the website.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					Policy SC_UMXX_118, Utilization Management Decision and Screening Criteria, describes how individual circumstances and clinical information pertaining to cases are reviewed and compared to UM criteria. A physician reviewer can approve requested services when criteria is not met, and the clinical evidence supports the decision.
5. Utilization management standards/criteria are consistently applied to all members across all reviewers.	X					Policies such as SC_UMXX_120, Nurse Inter-Rater, and SC_UMXX_078, Physician Inter-rater Reliability Assessment, describe Healthy Blue's process for conducting annual inter-rater reliability testing. All nurses and behavioral health reviewers, as well as physician reviewers, achieved passing scores above the respective goals after remedial training was completed.
6. Pharmacy Requirements						
6.1 Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts.	X					Pharmacy benefit information is available in the Pharmacy Program Description, Policy A08, Pharmacy Prior Authorization, the Member Handbook, the website, and the Provider Manual. The PDL provides formulary restrictions and indicates medications that require prior authorization, limitations, or step therapy. As a follow up from the previous EQR, Policy SC_CAXX_079, Case Management/New Enrollment: Transition Assistance-Continuity of Care was updated to reflect Healthy Blue will honor prescriptions for

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						new members who come into the health plan for up to 90 days.
6.2 If the MCO uses a closed formulary, there is a mechanism for making exceptions based on medical necessity.	X					Policy A08, Pharmacy Prior Authorization describes Healthy Blue's process for approving medications. Healthy Blue allows for a 3-day emergency supply of prescription drugs when a prior authorization is pending, as noted in the Pharmacy Program Description. As a recommendation from the previous EQR, Policy A08, Pharmacy Prior Authorization was updated to include the requirement that the plan shall not require the member's involvement or participation in the resolution of a prescription issue.
7. Emergency and post stabilization care are provided in a manner consistent with the contract and federal regulations.	X					
8. Utilization management standards/criteria are available to providers.	X					
9. Utilization management decisions are made by appropriately trained reviewers.	X					Healthy Blue ensures UM decisions are conducted by appropriate staff as described in the UM Program Description and Policy SC_UMXX_118, Utilization Management Decision and Screening Criteria. Non-licensed staff collect structured clinical data and approve services with clear criteria without interpretation of clinical information. Level 1 reviews are conducted by a licensed nurse. Only physicians or other appropriately licensed health care professionals issue adverse benefit

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						determinations. Reviewed files with adverse benefit determinations reflect decisions are made by appropriate physician specialists.
10. Initial utilization decisions are made promptly after all necessary information is received.	X					Service authorization timeframes for approval files are consistent with Policy SC_UMXX_117, Decision and Notification Timeframes, the UM Program Description, and *SCDHHS Contract* requirements.
11. Denials						
11.1 A reasonable effort that is not burdensome on the member or the provider is made to obtain all pertinent information prior to making the decision to deny services.	X					
11.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					
11.3 Denial decisions are promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal.	X					Review of denial files revealed adverse benefit determinations are timely and notice to the requesting provider and member was communicated according to processes described in Policy SC_UMXX_117, Decision and Notification Timeframes. Adverse benefit determination notices are written in language that is clear, without medical jargon, and easily understood by a layperson. Member and provider notices include contractually required

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						information, such as the action taken by the plan, the member's right to file an appeal with Healthy Blue, and to request a State Fair Hearing.
V C. Appeals *42 CFR § 438.228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260*						
1. The MCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the MCO in a manner consistent with contract requirements, including:	X					Healthy Blue's appeals processes are described and outlined Policy SC_GAXX_051, Member Appeal Process. Additionally, appeals information is provided in the Member Handbook and Provider Manual.
1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal;	X					Definitions of the terms "appeal" and "adverse benefit determination," and a description of who may file an appeal, are correctly documented in Policy SC_GAXX_051, Member Appeal Process. Healthy Blue defines and provides examples of people who can be an authorized representative acting on the member's behalf.
1.2 The procedure for filing an appeal;	X					Requirements for filing an appeal are documented in Policy SC_GAXX_051, Member Appeal Process, the Member Handbook, and the Provider Manual according to requirements in the *SCDHHS Contract Section 9*. Healthy Blue provides instructions, including mailing address and phone numbers, for appeals to be filed either orally or written and will acknowledge the appeals in writing within five business days. All appeals are logged and tracked into the appeals database.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The Member Appeal Request Form is available in the "grievances and appeals" section under the "Member Handbook and Materials" tab on the member website. CCME identified appeals information at the bottom of the website under the hyperlink "Our Quality Standards" and at the top of the website page under the "Benefits" tab. Although the website was updated to include appeals information as recommended from the previous EQR, these headings do not convey or identify that appeals information is located there, which can be a barrier for members wanting to file an appeal. *Recommendation: Provide appeal information on the member's website in a manner that is clearly recognizable and in a location that can be easily accessed, such as under the "Grievance and appeals" tab.*
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					Appeals involving medical necessity or clinical issues were reviewed by the medical director according to processes described in Policy SC_GAXX_051, Member Appeal Process.
1.4 A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	X					Timeframes for resolving appeals are appropriately documented. Healthy Blue resolves standard appeals and gives notice within 30 calendar days of receipt and expedited appeals within 72 hours of receipt. If a request for an expedited appeal is denied, the member is notified, and the appeal is processed within the standard timeframe of 30 days.
1.6 Written notice of the appeal resolution as required by the contract;	X					
1.7 Other requirements as specified in the contract.	X					
2. The MCO applies the appeal policies and procedures as formulated.		X				Review of appeals files reflected Healthy Blue's staff did not consistently process standard and expedited appeal requests according to guidelines in Policy SC_GAXX_051, Member Appeal Process. The following issues were noted: •Two versions of appeal case file letters were utilized; one version instructed members to respond with additional information within 10 calendar days from the date on the letter and the other version did not provide a timeframe to respond. During the onsite Healthy Blue staff explained appeal case letters were updated in January 2021, to include instructions for members to respond with additional information within 10 calendar days from the date on the letter. This update was a recommendation from the 2020 EQR.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•Appeal case files were not sent to members within 10 calendar days, as stated on page four of Policy SC_GAXX_051, Member Appeal Process, thus not allowing adequate time for the member to respond prior to the determination. •Inconsistencies with obtaining member consent when an appeal was requested from a provider. *Quality Improvement Plan: Follow processes in Policy SC_GAXX_051, Member Appeal Process to ensure appeal case file letters are mailed to members within 10 days of receiving the appeals request and to ensure member consent is obtained when an appeal is requested from a someone other than the member.* *Recommendation: Ensure the updated appeal case file letters are utilized when processing member appeal requests, allowing the member 10 calendar days to respond to the plan.*
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Member appeals are reviewed by the SQIC to identify and address trends. Review of SQIC minutes confirms discussion of appeals activities.
4. Appeals are managed in accordance with the MCO confidentiality policies and procedures.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V. D Care Management and Coordination *42 CFR § 208, 42 CFR § 457.1230 (c)*						
1. The MCO formulates policies and procedures that describe its case management/care coordination programs.	X					The Population Health Program Description, the Case Management Program Description, and the Maternal Child Services Program Description outline the framework for case management/care coordination and program goals, objectives, lines of responsibility, and operations for physical and behavioral health services. Policies and procedures, such as Case Manager Planning and Facilitation and Policy SC_CAXX_007, Care Management Targeting / Case Finding, describe Healthy Blue's approach to ensuring care management services and activities are provided according to *SCDHHS Contract* requirements.
2. The MCO has processes to identify members who may benefit from case management.	X					Through a monthly continuous case finding process, Healthy Blue identifies members who can benefit from case management services. Policy SC_CAXX_007, Care Management Targeting / Case Finding, describes methods for identifying and referring members into the Care Management Program. In addition to performing an annual population assessment, members are also identified from claims data, laboratory and health risk assessment results, predictive modeling software, and internal and external referrals.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The MCO provides care management activities based on the member's risk stratification.	X					Healthy Blue's approach to care management is outlined in the Population Health Program Description and the Case Management Program Description. The Population Health Program stratifies members into three risk levels. Additionally, members are sorted by risk and stratified into five intervention groups ranging from zero to four, which corresponds to the level of CM. Additionally, members identified for OB Case Management are placed into one of four group levels; urgent, high, medium, and low, based on results of the OB High Risk screening.
4. The MCO utilizes care management techniques to ensure comprehensive, coordinated care for all members.	X					
5. Care Transitions activities include all contractually required components.						
5.1 The MCO has developed and implemented policies and procedures that address transition of care.	X					The "Transition of Care Reference Guide-Medicaid" addresses transition requirements according to the *SCDHHS Contract, Section 5.6*. Healthy Blue conducts appropriate referrals, monitoring, and

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						follow-up to ensure continuity of the member's care.
5.2 The MCO has a designated Transition Coordinator who meets contract requirements.	X					Policy SC_CAXX_110, Care Management Transition and Continuity of Care, and Policy SC_CAXX_097, Transition to Other Care When Benefits End, indicates that the Health Care Management Case Management Manager serves as the Transition Coordinator. However, the responsibilities listed in the "Title and Education & Licensure" tables in the Population Health Program Description and Complex Case Management Program descriptions do not reflect that the Case Management Manager is the Transition Coordinator. *Recommendation: Update the Population Health Program Description and the Complex Case Management Program Description to include an indication that the CM Manager is the designated Transition Coordinator who is responsible for oversight of transition of care activities.*
6. The MCO measures case management performance and member satisfaction, and has processes to improve performance when necessary.	X					Care Management performance is measured through a clinical and non-clinical audit program. The Case Management Program is evaluated annually and results from select metrics are analyzed for effectiveness and reported to appropriate committees.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The Case Management Satisfaction Survey policy explains that "at least annually, satisfaction with CM programs will be evaluated by analyzing member satisfaction with the Case Management process, by obtaining feedback from members via a member satisfaction survey."
7. Care management and coordination activities are conducted as required.	X					Care Management files indicate CM activities are conducted as required and Care Managers follow policies to conduct the appropriate level of service. CCME noted that HIPAA verification, identifying care-gaps, and social determinants of health are consistently addressed; unable to contact letters and education materials are appropriately utilized; CM staff ensured updated care plans were available; and Health Risk Assessment were completed timely.
V E. Evaluation of Over/ Underutilization						
1. The MCO has mechanisms to detect and document under-utilization and over-utilization of medical services as required by the contract.	X					Policies are in place to ensure that Healthy Blue monitors and analyzes relevant data to detect and correct patterns of potential or actual inappropriate under or over utilization which may impact health care services, coordination of care and appropriate use of services and resources.
2. The MCO monitors and analyzes utilization data for under and over utilization.	X					Healthy Blue analyzed and monitored data, and offered recommendations based on findings for several services in regard to utilization in the committee meetings and 2020 Under and Over Utilization report. ER visits continue to decline; UM

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						discharge planning with case management intervention will continue for acute care discharges. The selected procedures seem to be within standard utilization range for back surgery and tonsillectomy, with weight loss surgery rates reported as above the threshold for overutilization in males and females.

VI. DELEGATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V I. DELEGATION *42 CFR § 438.230 and 42 CFR § 457.1233(b)*						
1. The MCO has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions.	X					The Delegate/Vendor Oversight and Management Program describes pre-delegation assessment activities conducted to ensure proposed delegates can meet established contractual and applicable federal, state, and accreditation standards. During the pre-delegation assessment, the proposed delegate's internal organizational structure and compliance with applicable contracted activities, plans/programs and other processes is assessed. Once

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						delegation is approved, an agreement that describes the scope, functions, activities, and roles, and responsibilities of both the health plan and the delegate is executed. Credentialing delegation agreements are in place with the following entities: •AnMed Health •SC Department of Mental Health •MUSC •Prisma Health Midlands •Prisma Health Upstate •Regional Health Plus •Roper St. Francis •Vision Service Plan Additional delegation agreements are in place with the following entities: •AIM Specialty Health—call center and utilization management functions •CulturaLink—translation services •CyraCom International, Inc.—translation services •IngenioRx—pharmacy benefit management •CVS Caremark— claims, network, and customer service

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The MCO conducts oversight of all delegated functions sufficient to ensure that such functions are performed using those standards that would apply to the MCO if the MCO were directly performing the delegated functions.		X				Processes and requirements for delegation of health plan activities are found in the following: •Delegate/Vendor Oversight and Management Program •MCD-10, Credentialing Delegation •Utilization Management - Medicaid Delegation and Oversight •A65 - Pharmacy Benefit Manager Performance Oversight Documentation of delegation oversight was submitted for review. The following issues were identified: •For two delegates, the MCO Credentialing File Review Workbook does not indicate whether the delegates were monitored for querying the National Plan and Provider Enumeration System, as stated in Policy MCD-10, Medicaid Delegated Credentialing. This is a repeat finding from the previous EQR. •For one delegate, the MCO Credentialing File Review Workbook does not indicate whether the delegate was monitored for querying the Social Security Death Master File, as stated in Policy MCD-10, Medicaid Delegated Credentialing. •For five credentialing delegates, the MCO Credentialing File Review Workbook does not indicate

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						whether the delegates were monitored for collection of nurse practitioner collaborative agreements. *Quality Improvement Plan: Ensure credentialing and recredentialing delegates are monitored for conducting required queries of the National Plan and Provider Enumeration System and Social Security Death Master File, as well as collection of collaborative agreements between nurse practitioners and supervising physicians. This should be documented in the MCO Credentialing File Review Workbook used to assess credentialing delegates.*

VII. STATE-MANDATED SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V I I. STATE-MANDATED SERVICES *42 CFR Part 441, Subpart B*						
1. The MCO tracks provider compliance with:						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.1 administering required immunizations;	X					Healthy Blue follows the EPSDT periodicity schedule according to the American Academy of Pediatrics. Methods such as annual medical record reviews are used to ensure EPSDT requirements are tracked, and providers are informed of impending or missed EPSDT services.
1.2 performing EPSDTs/Well Care.	X					Healthy Blue has policies and procedures in place to track provider compliance with required immunization and EPSDT/Well Child visits, such as Policy SC_PCXX_009, Pediatric Preventive Services/Provision of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services. Discussions during the onsite indicated that several state-of-emergency restrictions and guidelines related to the COVID-19 pandemic in 2020, may have contributed to pediatric provider compliance with performing EPSDT/ Well Child visits. Healthy Blue will consider conducting a PIP related to developmental screenings to assist members with obtaining required EPSDT and immunization services.
2. Core benefits provided by the MCO include all those specified by the contract.	X					
3. The MCO addresses deficiencies identified in previous independent external quality reviews.			X			During the previous EQR, documentation of oversight of credentialing delegates did not indicate whether the delegates were monitored for querying the National Practitioner Databank and the National Plan and Provider Enumeration System. The current EQR

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						found that documentation of oversight of credentialing delegates did not indicate whether the delegates were monitored for querying the National Plan and Provider Enumeration System. *Quality Improvement Plan: Implement quality improvement plans from the External Quality Review to address all identified deficiencies.*